No. 89-1150

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.,

Petitioner,

v.

ROBERT WEINER, SR., MARGARET WEINER, MARK WEINER,
AND ROBERT WEINER, SR. AS PERSONAL REPRESENTATIVE
OF THE ESTATE OF STEVEN WEINER,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
FOURTH DISTRICT COURT OF APPEALS OF FLORIDA

PETITION FOR A WRIT OF CERTIORARI TO THE FOURTH DISTRICT COURT OF APPEALS OF FLORIDA

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QUESTIONS PRESENTED FOR REVIEW

1. Did the Fourth District Court of Appeal of Florida err in its holding which permitted assertion of state court jurisdiction and which applied state law to a cause of action which, under the Employee Retirement Income Security Act of 1974 (ERISA), can only be heard in a federal court applying federal law?

2. Did the Fourth District Court of Appeal of Florida err in holding that a business, purchasing insurance through a trade association group insurance plan, with eligibility limited to employees of the member businesses, was not covered by the protections and limitations of ERISA, merely because the employer was a small family business and the covered employees were also family members?

LIST OF PARTIES

Pursuant to Rules 21.1(b) and 28.1, Petitioner states that the following parties appeared in the Supreme Court of Florida:

a) Blue Cross and Blue Shield of Maryland, Inc.[1]
b) Robert Weiner, Sr.;
c) Mark Weiner;
d) Margaret Weiner; and
e) Robert Weiner, Sr., as Personal Representative of the Estate of Steven Weiner.

[1]Pursuant to Rule 28.1, the corporate affiliates of Blue Cross and Blue Shield of Maryland, Inc. are listed in Appendix G.

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RELEVANT STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1132 and 1144 (1985).

§1132. *Civil Enforcement*

(a) *Persons empowered to bring a civil action*

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan,-or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

(e) *Jurisdiction*

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

. . . . .

§1144. *Other laws*

(a) *Supersedure; effective date.*

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) *Construction and Application*

. . . . .

(6)(A) Notwithstanding any other provision of this section —

> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

. . . . .

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

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COURT OF APPEAL OF FLORIDA

PETITION FOR A WRIT OF CERTIORARI TO THE FOURTH DISTRICT COURT OF APPEAL OF FLORIDA

The Petitioner, Blue Cross and Blue Shield of Maryland, Inc., respectfully requests that this Court issue a Writ of Certiorari to review the decision of the Fourth District Court of Appeal of Florida in this case.

OPINIONS BELOW

The Opinion of the Fourth District Court of Appeal of Florida, dated April 26, 1989, is reported at 543 So.2d 794 (Fla. Dist. Ct. App. 1989) and is reproduced in Appendix A. The Order of that Court denying the Petition for Rehearing and Rehearing En Banc, dated June 19, 1989, is reproduced in Appendix B. The Order of a divided Supreme Court of Florida, denying the Petition for Review, is reproduced in Appendix F.[2]

JURISDICTIONAL STATEMENT

The Order of the Supreme Court of Florida denying review was entered on October 24, 1989. Thus, pursuant to Rule 20.2, Blue Cross and Blue Shield of Maryland, Inc.'s filing of the instant Petition at this time is proper. The jurisdiction of this Court is invoked under 28 U.S.C. §1257.

STATEMENT OF THE CASE

This case involves far more than an effort by an insurance company to set aside a multi-million dollar judgment (nearly all of which is comprised of punitive damages), which is invalid under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 *et seq.*, and which was rendered by a state court which had no subject matter jurisdiction.

In spite of the strongest Congressional mandate for exclusive federal regulation and jurisdiction, and unanimous decisions of this Court recognizing the complete preemptive effect of ERISA, displacing both state statutory and common law in the field, *Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41 (1987) and *Metropolitan Life Insurance Co. v. Taylor,* 481 U.S. 58 (1987), the Florida Fourth District

[2]Copies of the Final Judgment, and the two Orders on Plaintiffs' Motions for Attorneys Fees, entered in this matter by the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida, are reproduced in Appendices C, D, and E respectively.

Court of Appeal wrongly exercised jurisdiction over Respondents' claims. The claims were governed by ERISA, and should have been heard only in a federal court and decided only within the framework of ERISA's Congressionally-mandated limited scheme of remedies.

If the decision is allowed to stand, it threatens to remove thousands of employee benefit plans from the protection of ERISA. The goal of ERISA was to encourage employers to expand existing plans and to create new plans, for the benefit of millions of workers, a significant percentage of whom are employed by small businesses. This decision sanctions the enormously expensive state tort punitive damage litigation, involving employee benefit plans, which ERISA expressly sought to avoid. By striking at the heart of what this Court has referred to as "ERISA's crowning achievement," *i.e.*, exclusive federal authority to regulate the field of employee benefit plans, *Pilot Life*, 481 U.S. at 46, the decision threatens the creation, financial viability and continued existence of these plans.

The decision below caused grave injustice to Petitioner, and has the potential to undermine the strong protections Congress provided to employee benefit plans in ERISA. The Florida Appellate Court's wrongful assertion of jurisdiction — both judicial and legislative — calls into play this Court's role as a final guarantor of federal rights in our federal system.

Petitioner, Blue Cross and Blue Shield of Maryland, Inc. ("BCBSM"), is a non-profit Maryland corporation in the business of providing health insurance. In 1980, Association Financial Services, Inc. ("AFSI"), a brokerage firm which administers health insurance benefits for national level trade associations, decided to create a group health insurance plan for the members of state service station dealers' associations that were affiliated with the Service Station Dealers of America ("SSDA"). BCBSM agreed to underwrite the plan.

Three contracts were executed naming the SSDA as the insured. The contracts created a "Group Plan" of health insurance. Enrollment was specifically limited to employees and dependents of employees of member companies of an SSDA affiliate. The Group Plan provided that participation (1) could only begin after BCBSM was notified that the applicant was an employee of a member company of an SSDA affiliate and (2) would be terminated on the last day of the month that a participant's employment status ended. The contracts required the SSDA affiliates to notify BCBSM each month of the changes in the status of employees.

The Group Plan contracts were assigned to AFSI which acquired the endorsement of the Allied Gasoline Retailers' Association of Florida ("AGRA"). AGRA, an association of employers, was the Florida affiliate of the SSDA. As a result, all of AGRA's members and their employees were eligible to enroll in the Group Plan, administered by AFSI on behalf of AGRA. Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), a non-profit Florida insurance company, serviced the Group Plan.

The Weiner Service Station ("Station") is located in Dania, Florida. Robert Weiner, Sr., Robert Weiner, Jr. and others work at the Station. Early in 1982, Robert Weiner, Sr. called AGRA's field representative, Al Jacobson, regarding the Group Plan. Jacobson met with Robert Weiner, Sr., explained the Group Plan to him, and gave him a benefit book. The benefit book stated that the coverage was only available to employees and their dependents and that when a participant's status as an employee ended, his insurance under the Group Plan ended. Since coverage was only available to employees of the Station if the Station was a member of AGRA, the Station joined AGRA and applied for insurance under the Group Plan. As a result, the "Station Plan" was formed.

Two applications were filled out for the Station's employees. Robert Weiner, Sr. applied for a "family policy,"

and his application listed him as an "employee" and showed "Weiner Service Station" as the "Name of Employer." Robert Weiner, Sr.'s family policy covered Robert Weiner, Sr. and his dependents, Margaret Weiner, Steven Weiner, and Mark Weiner. Robert Weiner, Jr. applied for an "individual policy," covering only himself, and his application also listed him as an employee and showed the "Weiner Service Station" as the "Name of Employer." Under the terms of the Group Plan, the Station was responsible for payment of premiums and the Station did pay the premiums for both Robert Weiner, Sr. and Robert Weiner, Jr.

In the Summer of 1982, Steven Weiner became seriously ill and was later diagnosed as having the Acquired Immune Deficiency Syndrome. Later that summer, Mark Weiner was involved in an accident and became a quadriplegic. Coverage for the Weiners was provided from the Summer of 1982 until August 8, 1983. On that date, BCBSM determined that Steven Weiner and Mark Weiner were no longer covered by the Group or Station Plans by reason of each having reached the age of nineteen, and the payment of benefits was discontinued.

In September 1983, Robert Weiner, Sr. filed suit against BCBSM and BCBSF in the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida (the "State Trial Court") alleging that they had improperly denied benefits to Robert Weiner, Sr. and consequently, breached their duty of good faith and fair dealing, breached their fiduciary duty, committed fraud, and violated a Florida statute.

In March 1984, BCBSM informed the Weiners that it would reinstate coverage and pay all back claims due. It has processed all claims and paid all contractual benefits due under the Group and Station Plans.

In December 1984, the original Complaint was amended and Margaret Weiner, Mark Weiner, and Robert Weiner, Sr., as Personal Representative of the Estate of Steven Weiner,

were added as plaintiffs. In December 1985, the Weiners filed a Second Amended Complaint. In that Complaint, the Weiners alleged that BCBSM and BCBSF had committed three common law torts - fraud, intentional infliction of mental distress, and negligence. They eliminated all claims for unpaid benefits. The Second Amended Complaint sought recovery of compensatory and punitive damages.

On September 25, 1986, a jury verdict was returned in favor of the Weiners. The jury found BCBSM liable for fraud, intentional infliction of mental distress, and negligence and returned a verdict against BCBSM for $500,000 compensatory damages and $5,000,000 punitive damages. The jury also found BCBSF liable for fraud and intentional infliction of mental distress and returned a verdict against BCBSF for $200,000 compensatory damages and $1,500,000 punitive damages. In addition, the State Trial Court awarded attorneys' fees to the Weiners against BCBSM and BCBSF jointly in the amount of $1,411,600 (based upon three times the lodestar rate calculation). BCBSM and BCBSF appealed to the Florida Fourth District Court of Appeal (the "State Appellate Court").

In April, 1987, after the jury verdict but before briefing on the appeal, this Court issued its opinions in *Pilot Life* and *Metropolitan Life*. Reversing decisions of two federal circuit courts, this Court held that a plan participant's state common law tort claims (*i.e.*, all of the claims at issue in the *Weiner* case) were preempted; indeed, they were completely displaced by ERISA. Under ERISA, the state court could not have tried the case, the remedies awarded by it (punitive damages and huge attorneys' fees) could not have been granted, and a jury trial could not have been had. (*See* Reasons for Granting the Writ.)

BCBSM and BCBSF raised the issue of lack of subject matter jurisdiction in their appeal. This was the first time this federal question was raised in the case. See this Court's Rule 21(h). In both its Initial Brief (at 17) and Reply Brief (at

14), BCBSM specifically requested the State Appellate Court to dismiss the case for lack of subject matter jurisdiction or, at a minimum, to remand the case for a full evidentiary hearing upon whether the insurance plans were covered by ERISA.[3]

On April 26, 1989, the State Appellate Court affirmed the State Trial Court's judgment and award as to BCBSM and reversed the State Trial Court's judgment and award as to BCBSF.

With respect to the newly-raised ERISA issue, the Court acknowledged that the material facts (partial though they were) were "disputed," but, in effect, granted summary judgment on appeal concerning that issue. (App. A at 9-10.) Its decision concerning the pivotal ERISA issue was astonishingly brief and equally deficient:

> [Blue Cross/Blue Shield of] Maryland's principal assertion on appeal is that there is a lack of jurisdiction over the subject matter because the plaintiffs' claim is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001-1461, ("ERISA"), and that state courts do not have concurrent jurisdiction. *See also Pilot Life Insurance Co. v. Dedeau* (*sic*), 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). However, we find that ERISA does not apply to this policy.

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[3]Since the issue of ERISA's applicability was not presented to the State Trial Court, the record upon that issue was incomplete.

In 1988, before the 1989 decision by the State Appellate Court, BCBSM filed suit in the United States District Court for the Southern District of Florida, asking that Court to declare that the State Trial Court judgment was void since the causes of action had been preempted by ERISA, and the matter was one exclusively within the jurisdiction of the federal courts. The United States District Court abstained, in an unreported decision. That decision was affirmed (upon different grounds of abstention) by the United States Court of Appeals for the Eleventh Circuit. 868 F.2d 1550 (11th Cir.), *cert. denied,* ____ U.S. ____ (October 10, 1989). The Eleventh Circuit decision also was rendered before the decision by the State Appellate Court.

> ERISA regulates employee benefit plans, including ones providing for medical and hospital care, if the plan is established or maintained by an employer or employee organization, or both. ERISA §4(a), 29 U.S.C. §1003(a). Here, the record does not support a conclusion that there was an employee plan. The record does not reveal any agreement between the service station dealers associations and Maryland or AFSI. The evidence, although disputed, reflects that the plaintiff here was a sole proprietor who simply purchased a group policy for his family. *See Xaros v. U.S. Fidelity and Guaranty Co.*, 820 F.2d 1176 (11th Cir. 1987); *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982); *Taggart Corp. v. Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980). Here there was no plan, or even an informal agreement, established or maintained by an employer or an employee organization. Nor were any fiduciary responsibilities created by this insurance marketing scheme, which simply made group insurance available to members of the organization.

(App. A at 9-10.) BCBSM's Motion for Rehearing and Rehearing *En Banc* was denied. (App. B.) The Supreme Court of Florida then denied BCBSM's request for review. (App. F.)[4]

REASONS FOR GRANTING THE WRIT

A. Introduction

ERISA, enacted by Congress in 1974, is a complex and thorough law governing employee benefit plans. This Court has recognized that ERISA "comprehensively regulates,

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[4]In July, 1989, the Weiners sought to enforce their Florida judgment in Maryland, a judgment which (with interest) has now grown to over $9 million. BCBSM launched a collateral attack on that judgment, alleging lack of subject matter jurisdiction in the Florida Trial Court, relying upon the principles recited in *Kalb v. Feuerstein*, 308 U.S. 403 (1940) and *Restatement (Second) of Judgments*, §12 (1982); *see generally* 13A Wright, Miller & Cooper, *Federal Practice & Procedure*, §3536 at 539-40 (1984). The United States District Court for the District of Maryland now is considering whether to permit collateral attack, *i.e.*, if it will grant a hearing on the issue of whether there was an ERISA plan in this case.

among other things, employee welfare benefit plans", *Pilot Life,* 481 U.S. at 44, and has observed on several occasions that the provisions of ERISA "are deliberately expansive and designed to establish pension plan regulation as exclusively a federal concern." *Pilot Life,* 481 U.S. at 46 (*quoting Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 523 (1981)). In establishing ERISA's comprehensive scheme, Congress balanced ERISA's broad coverage with limited remedies, thus effectuating a trade-off between coverage and liability which must be enforced and protected by the federal courts. *Pilot Life,* 481 U.S. at 54.

To ensure that ERISA remained a matter of exclusively federal concern and that participants and beneficiaries would have ready access to the federal courts, Congress provided that in all ERISA cases except those brought under §1132(a)(1)(B) — suits to recover plan benefits (a section not applicable here) — the federal courts would have exclusive jurisdiction. 29 U.S.C. §1132(e)(1).

In order to make ERISA's remedies exclusive and nationally uniform, Congress also provided ERISA with a unique and extraordinary preemption provision. 29 U.S.C. §1144. In *Pilot Life,* a plan participant whose benefits had been terminated alleged several state common law torts, including breach of fiduciary duty and fraud, and sought to recover compensatory damages for mental and emotional distress and punitive damages. This Court held that the plan participant's state common law tort claims were completely preempted by ERISA.

This Court began by recognizing the two basic tenets of ERISA preemption: (1) ERISA preempts any state law that "relates to" an employee benefit plan and (2) the only exception to this rule is if the state law is one "which regulates insurance." 481 U.S. at 45. This Court held that under the "broad common-sense meaning" of the term "relates to," the participant's state common law torts alleging improper processing of claims under an employee

benefit plan related to the plan. *Id.* at 47. In addition, this Court held that common law torts are not laws specifically designed to regulate insurance. *Id.* at 50-51. This Court therefore held that state common law torts based on alleged improper processing of claims under an employee benefit plan "undoubtedly meet the criteria for preemption." *Id.* at 48.

On the same day that this Court decided *Pilot Life,* it also decided *Metropolitan Life,* going one step further by holding that not only does ERISA preempt state common law torts, it totally displaces them. This Court referred by analogy to its prior decisions regarding the preemptive effect of §301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. 185, which is so powerful that preemption — normally a defense — becomes self-acting and destroys any state law claim infringing on the federal statute. This Court held that because ERISA's preemption provision was modeled after §301, ERISA similarly displaces state common law tort remedies with the remedies provided for in §1132(a).

Preemption of this magnitude is a matter of subject matter jurisdiction; therefore, this Court has held that if a state law claim is preempted, the state court loses its jurisdiction over the matter. *Metropolitan Life,* 481 U.S. at 6667; *see also Int'l Longshoremen's Ass'n v. Davis,* 476 U.S. 380, 391-392 (1986). ERISA is remarkable in that it provides for both exclusive federal jurisdiction and complete preemption of state law claims. Even other statutes evidencing the strongest of federal interests do not provide for such comprehensive federal dominance of their fields, *e.g.,* the LMRA (preemption without exclusive jurisdiction) and the Sherman Act (exclusive jurisdiction without preemption).

As will be demonstrated below, the Weiners' state tort claims were preempted by ERISA and were within the exclusive jurisdiction of the federal courts. The State Appellate Court's decision is fatally flawed, as a matter of

law and fact. The vitally important policies which Congress sought to protect by making ERISA exclusively a matter of federal concern, to insure *consistent* regulation and *limited* remedies, *Pilot Life,* 481 U.S. at 46, are undermined by that decision.

B. This Court Should Grant Certiorari Because the Decision of the Court Below That There Was No ERISA Plan Is Inexplicable As a Matter of Law and Fact

Despite the existence of an issue which was never litigated, and a limited and "disputed" factual record, the State Appellate Court concluded that the policy at issue was not an ERISA-covered employee welfare benefit plan. 543 So.2d at 798. (App. A at 9-10.) The State Appellate Court based its decision on its conclusion that Robert Weiner, Sr. was a sole proprietor of a business who simply purchased a group insurance policy for his family. *Id.*

This incredible decision is wholly unsupported in law or fact. It is absolutely clear (even on the partial record before the State Appellate Court) that *both* the Group Plan and the Station Plan satisfy the ERISA definition of an "employee welfare benefit plan."

The State Appellate Court's finding stands in direct contradiction to the decision of the United States Court of Appeals for the Ninth Circuit in *Kanne v. Connecticut General Life Ins. Co.,* 867 F.2d 489 (9th Cir. 1988), *cert. denied,* ____ U.S. ____, 109 S. Ct. 3216 (1989). In Kanne, the Ninth Circuit unanimously held that an employer association-sponsored group insurance plan is an ERISA plan.

The facts in *Kanne* are virtually identical to those in *Weiner.* As in the present case, the plaintiff (as well as his dependents) was covered under a health insurance plan by virtue of his employment with the employer. As in the present case, the employer belonged to a trade association which offered a group insurance plan to participating

employers. As in the present case, the employer subscribed to the group plan in order to provide medical coverage to its employees and their dependents. Finally, as in the present case, the employer association arranged to have the defendant insurance company underwrite the group plan.

In finding the employer association plan to be an ERISA plan, the Ninth Circuit initially relied upon ERISA's broad definition of the term "employee benefit plan," 29 U.S.C. §1002(1). Section 1002(1) defines an employee welfare benefit plan as follows:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

Thus, the five statutory components of an employee welfare benefit plan are: (1) a plan, fund or program, (2) established or maintained, (3) by an employer or by an employee organization or both, (4) for the purpose of providing benefits, (5) to participants or their beneficiaries. *See Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986); *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982); *Wickman v. Northwestern National Life Insurance Co.*, 9 EBC 1482, 1484 (D. Mass. 1987).

The Group Plan offered by AGRA qualifies as an employee welfare benefit plan under the five-part test set out by the Eleventh Circuit in *Donovan*. First, the Group Plan is a "plan, fund, or program." As *Donovan* points out, to meet this first requirement, there must be intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits. 688 F.2d at 1372. The Group Plan contracts clearly demonstrate that health

insurance is the intended benefit and that the benefits are provided to the employees of AGRA members and their dependents. In addition, AGRA members finance the Group Plan and the Group Plan contracts set out a full and detailed procedure for the application and collection of benefits. Therefore, the Group Plan meets the first *Donovan* requirement.

The Group Plan also satisifies the second *Donovan* requirement. The *Donovan* court held that the determination of whether a plan has been "established or maintained" turns on whether "a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Id.* at 1373. The Group Plan contracts spell out each of these elements: health insurance is the intended benefit, employees of AGRA members and their dependents are the intended beneficiaries, payments by AGRA members finance the plan, and the Group Plan contracts set out the procedure for receiving benefits.

The third *Donovan* requirement is also satisfied by the Group Plan. An "employer" is defined by ERISA to include "a group or association of employers acting for an employer." 29 U.S.C. §1002(5). AGRA is an association of service station dealer-employers that acts for the benefit of its employer members. Thus, AGRA is an "employer."[5]

The fourth and fifth Donovan requirements are also satisfied. The Group Plan provides medical, surgical, and hospital care benefits, and the beneficiaries of the Group

[5]Respondents have argued below that the Group Plan was "established and maintained" by AFSI — an "entrepreneurial business" — rather than by AGRA. It is true that AFSI, a company in the business of arranging group insurance coverage for trade associations, obtained the agreement of BCBSM to underwrite group plans endorsed by state service station dealer associations who were affiliated with the Service Station Dealers of America. But it is undisputed that, until the individual state association *endorsed* the plan and offered it to its member companies, no state plan came into existence. Thus, for ERISA purposes, the state association "established and maintained" the Group Plan.

Plan are the employees of AGRA members and their dependents. Consequently, the Group Plan established by AGRA meets the fourth and fifth requirements and qualifies as an employee benefit plan.[6]

In addition to relying upon the ERISA definition of an "employee welfare benefit plan," the Ninth Circuit in *Kanne* also accorded great weight to Department of Labor Regulations. Those Regulations, 29 C.F.R. §2510.3-1(j) (1989), set forth four requirements that a group insurance program must meet in order to fall *outside* the definition of an ERISA employee welfare benefit plan.

The Ninth Circuit made clear that it is *not* necessary for the program to fail to satisfy *all* four requirements to be an ERISA plan. To the contrary, a finding that "*any one* [has not been met] would prevent the exclusion of the insurance plan from ERISA coverage." *Kanne*, 867 F.2d at 492 (emphasis added).

Of the four findings that must be made to exclude a group insurance program from ERISA, three concern the role of the "employer" vis-a-vis the program:

> (1) no contributions are made by an employer . . .;
>
> . . . .
>
> (3) the sole functions of the employer . . . with respect to the program are, *without endorsing the program*, to permit the insurer to publicize the program to employees, . . . to collect premiums through payroll deductions . . . and to remit them to the insurer; and
>
> (4) the employer . . . receives *no consideration* in the form of cash or otherwise in connection with the

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[6]Respondents have argued that the Group Plan did not comply with ERISA's administrative and reporting requirements. This is incorrect. In any event, failure to comply with these requirements does not prevent ERISA coverage of a plan if one, in fact, has been established. Nor does such failure evidence the lack of a plan in the first instance. *Donovan*, 688 F.2d at 1372; *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503 (9th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985); *Adam v. Joy Mfg. Co.*, 651 F. Supp. 1301, 1306 (D.N.H. 1987).

> program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions . . . .

29 C.F.R. §2510.3-1(j) (1989) (emphasis added).

The strong involvement of both the Weiner Service Station and AGRA, in connection with the Group Plan, where both are "employers" under the ERISA definition, causes the Group Plan to fail at least *three* of the four stated criteria for a *non*-ERISA plan:

(1) The Group Plan contracts provide that the "*Company* shall pay" the premiums each month for each eligible employee. In fact, it is undisputed that the Weiner Station actually paid the premiums. Thus, "contributions are made by an employer."

(3) AGRA *endorsed* the Group Plan and had its representatives enroll participating employers and their employees. Thus, AGRA, an ERISA employer, did more than merely publicize the program and collect premiums.

(4) AGRA received a per capita administrative fee to compensate it for endorsing and marketing the plan. Thus, AGRA, an ERISA employer, received consideration beyond administrative fees for merely making payroll deductions.

Under the Ninth Circuit's holding in *Kanne,* therefore, there can be no doubt that the AGRA Group Plan is an ERISA plan[7].

That the State Appellate Court was flatly wrong in deciding otherwise is illustrated by the three cases the Court cited to support its conclusion. Two of these cases, *Xaros v. U.S. Fidelity and Guar. Co.,* 820 F.2d 1176 (11th Cir.

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[7] In *Lambert v. Pacific Mut. Life Ins. Co.,* 259 Cal. Rptr. 398 (Cal. Ct. App. 1989), a California state appellate court used a similar analysis to find that a group insurance plan offered by an employer association, under which participating employers provided medical coverage to employees, was an ERISA plan. As in *Kanne,* the facts before the court in *Lambert* virtually mirror the present case.

1987), and *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), are clearly inapposite here, while the third case, *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), supports BCBSM's position.

In *Xaros*, the Eleventh Circuit simply held that subcontractors and sureties, all nonsignatories to a collective bargaining agreement, are not employers under the ERISA definition. For that reason, there was no subject matter jurisdiction over a claim against the nonsignatories for a signatory's failure to make contributions to a multiemployer employee benefit plan. Obviously, that decision has no application to the facts here.

Taggert is similarly irrelevant, since that decision involved a multiple employer trust (commonly referred to as a "MET"), not an employer-association endorsed group plan. A MET is a trust formed solely for the purpose of selling group health insurance to employees of *unrelated* employers who do not belong to an employer association. A MET plan is not an ERISA plan—an employer association plan is.

This has been the position of the Department of Labor at least since the publication of its News Release of August 6, 1979, where it stated that "a multiple employer plan [ERISA plan] can be established only if the employers are *members of an organized group or association*," and that "a MET arrangement is not a plan under ERISA if *unrelated* employers have merely adopted identically worded agreements that are offered by an independent third party . . . ." Department of Labor News Release No. 553, 5 *Pens. Plan Guide* (CCH) 22,194 (Aug. 10, 1979). (emphasis added).

The State Appellate Court's complete confusion over the ERISA issue is illustrated further by its reliance on *Donovan*. *Donovan* involved a MET which everyone agreed was not an ERISA plan because subscribers included unrelated employers and unions. Nonetheless, the Eleventh Circuit, in a unanimous *en banc* decision, concluded that

many of the employers and unions that subscribed to the MET in order to provide health insurance for employees or members established *their own* individual employee welfare benefit plans that were subject to ERISA.

Thus, contrary to the State Appellate Court, not only is the AGRA Group Plan an ERISA plan, the Station Plan *also* qualifies as an individual "employee welfare benefit plan," *i.e.*, an ERISA plan. An employee welfare benefit plan may be created without a formal, written plan. *Donovan*, 688 F.2d at 1372; *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504 (9th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1984); *Wickman v. Northwestern National Life Insurance Co.*, 9 EBC 1482 (D. Mass. 1987). In addition, Department of Labor Regulations establish that an employer needs only one common law employee to qualify as an "employer" under ERISA. 29 C.F.R. 2510.3-3 (1989). The Station was an employer, since at least Robert Weiner, Sr. and Robert Weiner, Jr. were employed at the Station, and both Robert Weiner, Sr. and Robert Weiner, Jr. applied for insurance under the Group Plan as employees of the Station. By joining the Group Plan, the Station provided its employees and their dependents with the opportunity to receive health insurance and formed an ERISA-covered employee welfare benefit plan.[8]

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[8]The State Appellate Court found that Robert Weiner, Sr. ran the Station as a sole proprietor, and that his purpose in purchasing insurance was to provide coverage for his family. This is a *non sequitur*; family protection is a goal of most ERISA plan participants. More importantly, it is *undisputed* that one son was covered only because of his employee status. Finally, it would be irrelevant legally, but also disingenuous to argue that, while that son worked for the Station, no insurance was purchased for any other "employees." In his deposition taken in the case, on April 25, 1986, Robert Weiner, Sr. testified that he had no employees besides his son, and that the other individuals who worked at the station (including an attendant who pumped gas) were "independent contractors." Assuming *arguendo* that Mr. Weiner was truthful, it is obvious that reliance on the fact that no insurance was purchased for any other employees to support an argument that the Group Plan was not an ERISA plan is specious, since there *were* no other employees. In any event, it is

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In addition to its unremarkable finding that the MET before it was not an ERISA plan, the Fifth Circuit in the *Taggart* case also held that the Taggart Corporation, by subscribing to the MET, had *not* established an individual employee welfare plan that was covered under ERISA. As discussed above, the Eleventh Circuit in *Donovan* severely limited this second *Taggert* holding. 688 F.2d at 1375; *See also Wickman,* 9 EBC at 1488.

In any case, *this second Taggart holding is no longer the law.* The remarks of Congressman Erlenborn, a co-sponsor of the 1983 amendment to ERISA (part of the Miscellaneous Tax and ERISA Provisions, Pub. L. No. 97-463, 96 Stat. 2605), demonstrate that Congress was so troubled by the second *Taggart* holding that it expressly overruled the holding when it amended ERISA in 1983 to add, *inter alia,* §1144(b)(6)(C). He stated:

> Another provision (new ERISA section 514(b)(6)(C)) clarifies present law and deals with a question which has arisen as to whether ERISA applies to any aspect of a multiple employer welfare arrangement which does not meet the ERISA welfare plan definition (hereinafter referred to as a MET).
>
> Since employers frequently subscribe to these MET arrangements to provide employees with welfare benefits, there is a strong presumption that ERISA applies. The Department of Labor, which has taken the position that the MET itself does not constitute a single umbrella-like employee benefit plan, has consistently maintained that *each employer or union which subscribes to the MET has established its own employee benefit plan.* Under this analysis, the MET is not a single large plan, but rather a funding vehicle for a number of small individual employee benefit plans.
>
> *The Department of Labor's analysis is entirely consistent with the congressional intent under ERISA.*

---

undisputed that "employee status" was required for eligibility under the Group Plan, and that Robert Sr. and Robert Jr. could only be eligible because of their employee status — not because of their familial ties. That alone is dispositive of the State Appellate Court's "family" coverage distinction. (App. A at 9-10.)

> Nevertheless, the Court of Appeals for the Fifth Circuit, in *Taggart Corp. v. Life & Health Benefits Administration,* 617 F.2d 1208 (5th Cir. 1980), has held that ERISA does not apply to the plans which subscribe to the MET. Even more disturbing is the reasoning of this decision which holds that employers which purchase insurance to underwrite benefits and/or which hire third parties to administer the plans do not establish welfare plans covered by ERISA. *This reasoning is wholly inconsistent with the language of ERISA, its legislative history, the case law and the shared understanding of the employee benefit plan community. It is also a critical issue because it affects the jurisdictional scope of ERISA.*
>
> While there is every reason to believe that the courts will readily see the error of the Taggart decision (e.g., the Court of Appeals for the 11th Circuit has in an en banc hearing ruled that ERISA applies to the "plans" that subscribe to a MET) to reconsider the Taggart decision, section 514(b)(6)(C) makes it clear *that welfare plans which subscribe to or use MET's as a funding vehicle are subject (as ERISA plans) to the provisions of title I, including the preemption provisions (which preempt State law in connection with such plans).*

128 Cong. Rec. 30,357-58 (1982) (emphasis added).

In this case, therefore, even were the AGRA group insurance plan a MET (which it is *not*), the Weiner Station nonetheless would have established an ERISA plan by subscribing to the MET. *A fortiori,* the Weiner Station must have established an ERISA plan when it subscribed to an employer group association plan which is not a MET, but which is itself an ERISA plan.

C. This Court Should Grant Certiorari Because the Decision of the Court Below Threatens to Substantially Weaken ERISA and the Important Federal Interests Served by ERISA.

The State Appellate Court ignored established, undisputed federal precedent and relied upon mere instinct to conclude that the plan at issue was not an ERISA plan. The State Appellate Court assumed that a small business

owned by a sole proprietor would not be creating an ERISA plan by buying health insurance for two employees. However, the statute, the decisions of this Court and those of the lower federal courts establish that ERISA applies to *all* employers, whether large or small.

The State Appellate Court overlooked the fact that millions of American workers are employed by small business, and that Congress desired that they be covered by ERISA, just as are the workers in large businesses. The State Appellate Court also overlooked the fact that the plan at issue is sponsored by an association of small employers, most if not all of whom would be unable to obtain similar insurance individually at the same rates.

The State Appellate Court decision is extraordinary, and its scope is potentially far-reaching. By eliminating an entire class of businessses from coverage by ERISA, that decision would allow assertion of the state law punitive damage claims from which ERISA shields employee benefit plans. Moreover, acceptance of that decision threatens the important Congressional goal of avoiding conflicting or inconsistent state and local regulation of employee benefit plans. *Pilot Life,* 481 U.S. at 46.

We reiterate that the decision, astounding on its face, was reached by resolving, summarily on appeal and on "disputed" facts, an issue which has never been litigated: whether the plans at issue were ERISA plans.[9]

The State Appellate Court decision in this case is exactly the type of state judicial involvement which Congress intended to prevent when it enacted ERISA's broad preemption provision. This Court, in *Metropolitan Life,* held that ERISA's remedies totally displace those provided for in state tort law. Had this suit been brought in federal court, as ERISA requires, the litigation would have taken a vastly different course.

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[9]Resolution of factual issues genuinely in dispute is, of course, a matter for the trier of fact, and cannot be accomplished on summary judgment. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248-49 (1986). For this reason alone the State Appellate Court's decision should be reversed.

First, extra-contractual damages, including punitive damages, cannot be recovered in an ERISA action. *Massachusetts Mutual Life Ins. Co. v. Russell,* 473 U.S. 134 (1985).[10]

Thus, had this case been tried in federal court under established ERISA law, extra-contractual damages of any type, including punitive damages and damages for intentional infliction of mental distress, could not have been awarded. Under Florida tort law, however, these damages are recoverable. Consequently, because this case was decided under state common law and not ERISA, BCBSM and BCBSF were found liable for $7,200,000 in extra-contractual damages.

Second, the award of attorneys' fees would also have been very different if this case had been brought in federal court under ERISA. Although this Court has never addressed this issue, numerous federal courts have set forth detailed guidelines governing when attorneys' fees should be granted in an ERISA case. *Gray v. New England Tel. & Tel. Co.,* 792 F.2d 251 (1st Cir. 1986); *McKnight v. Southern Life and Health Ins. Co.,* 758 F.2d 1566 (11th Cir. 1985); *Lawrence v. Westerhaus,* 749 F.2d 494 (8th Cir. 1984); *Marquardt v. North American Car Corp.,* 652 F.2d 715 (7th Cir. 1981); *Hummell v. S.E. Rykoff & Co.,* 634 F.2d 446 (9th Cir. 1980); *Iron Workers Local No. 272 v. Bowen,* 624 F.2d 1255 (5th Cir. 1980); *Eaves v. Penn,* 587 F.2d 453 (10th Cir. 1978); *Ford v. New York Cent. Teamsters Pension Fund,* 506 F. Supp. 180 (W.D.N.Y. 1980), *aff'd,* 642 F.2d 664 (2nd Cir. 1981). These Courts have held that in determining whether to award attorneys' fees, the factors to be considered are: (1) the

[10]Although the holding of this Court in *Massachusetts Mutual* was expressly limited to ERISA §1109, numerous Circuit Courts of Appeal have since held that it is properly extended to ERISA §1132 cases, such as the case at bar. *See Varhola v. Doe,* 820 F.2d 809 (6th Cir. 1987); *Kleinhans v. Lisle Savings Profit Sharing Trust,* 810 F.2d 618 (7th Cir. 1987); *Sokol v. Bernstein,* 803 F.2d 532 (9th Cir. 1986); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.,* 793 F.2d 1456 (5th Cir.), *reh'g denied,* 797 F.2d 977 (5th Cir. 1986), *cert. denied,* 479 U.S. 1034, *cert. denied,* 479 U.S. 1089 (1987); *Powell v. C&P Telephone Co. of Va.,* 780 F.2d 419 (4th Cir. 1985), *cert. denied,* 476 U.S. 1170 (1986).

degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions.

These guidelines for the award of attorneys' fees in ERISA cases were not considered by the State Appellate Court in determining whether to award attorneys fees in this case. Rather, the award of attorneys' fees was based on a provision of the Florida Statutes permitting the award of attorneys' fees in controversies over the coverage of insurance policies. Thus, the initial decision whether to award attorneys fees *at all* would have been different had the case been brought in federal court under ERISA.

Moreover, the *amount* of attorneys' fees awarded under ERISA would have been different than the amount awarded by the State Appellate Court. The Third Circuit has stated that Congress did not intend the award of attorneys' fees for private enforcement of ERISA to be used as a means to inflict punishment. *Ursic v. Bethlehem Mines,* 719 F.2d 670 (3d Cir. 1983).[11]

Finally, while tort actions in Florida may be tried to a jury, the vast majority of the federal courts which have addressed the issue have held that jury trials are not

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[11]In a myriad of federal attorneys' fees cases, including this Court's decisions in *Blum v. Stenson,* 465 U.S. 886 (1984), and *Hensley v. Eckerhart,* 461 U.S. 424 (1983), the federal courts have established a well-structured procedure for the granting of reasonable attorneys' fees under federal law. The State Appellate Court found that a multiplier of three should be used for a substantial portion of the total lodestar. The use of this multiplier produced an attorneys' fees award that is far from reasonable. It is inconceivable that any federal court would have awarded three times the lodestar. Therefore, if this case had been litigated in the federal court, under ERISA, any award of attorneys' fees would have been considerably smaller, even assuming that the Weiners would have won.

permitted under ERISA.[12]

The danger posed by the decision under challenge here was recognized by Congress. Congress was concerned with the costs entailed by employee benefit plans, and sought to insure that ERISA would *encourage* the establishment of such plans. As stated by Representative Collier:

> [ERISA] should not be implemented in a way which will force employers to end their plans or perhaps discourage other employers from beginning them.

120 Cong. Rec. 29,209 (1974). Senator Williams expressed this concern explicitly:

> We have been told that [ERISA] will greatly increase the costs of private pension plans, something I am sure none of the Senators would like to see occur. This is particularly true if these increased pension costs result in the termination of private pension plans. Certainly this is not the intent of this legislation which is designed to improve and encourage the expansion of private pension plans.

120 Cong. Rec. 29,928 (1974). Congress' fear, articulated above, could become a reality if the State Appellate Court decision is permitted to stand. The decision surely will encourage the ruinous litigation and exorbitant insurance costs which will prevent businesses (especially small businesses) from adopting employee benefit plans.

This Court in *Pilot Life* explained the "careful balancing" represented by the civil enforcement scheme of §502(a) of ERISA, 29 U.S.C. §1132(a):

> In sum, the detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that

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[12] *See Cox v. Keystone Carbon Co.*, 861 F.2d 390 (3d Cir. 1988); *Chilton v. Savannah Foods & Indus., Inc.*, 814 F.2d 620 (11th Cir. 1987); *Howard v. Parisian, Inc.*, 807 F.2d 1560 (11th Cir. 1987); *Turner v. CF&I Steel Corp.*, 770 F.2d 43 (3d Cir. 1985), *cert. denied*, 474 U.S. 1058 (1986); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003 (4th Cir. 1985); *Katsaros v. Cody*, 744 F.2d 270 (2nd Cir.), *cert. denied*, 469 U.S. 1072 (1984); *In re Vorpahl*, 695 F.2d 318 (8th Cir. 1982); *Calamia v. Spivey*, 632 F.2d 1235 (5th Cir. 1980).

> represents a *careful balancing* of the need for prompt and fair claims settlement procedures against the *public interest in encouraging the formation of employee benefit plans . . . . [T]he federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.*

481 U.S. at 54 (emphasis added). The judgment in this case makes a mockery of this statement. The goals established by Congress in ERISA cannot be achieved unless all courts — state and federal — understand the unique and extraordinary nature of ERISA preemption, comprehend the importance of federal court jurisdiction over ERISA issues, and appreciate exactly what an ERISA plan is — and is not. This Court must grant *certiorari* in this case in order to prevent further, dangerous misinterpretation of ERISA's provisions.

CONCLUSION

For all of the foregoing reasons, BCBSM respectfully requests that this Court, as the guardian of the federal rights so clearly expressed in ERISA, issue a Writ of Certiorari to review the decision rendered in this case.

Respectfully submitted,

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Attorneys for Petitioner

January 22, 1990

89-1150

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.,

Petitioner,

v.

ROBERT WEINER, SR., MARGARET WEINER, MARK WEINER,
AND ROBERT WEINER, SR. AS PERSONAL REPRESENTATIVE
OF THE ESTATE OF STEVEN WEINER,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
FOURTH DISTRICT COURT OF APPEAL OF FLORIDA

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI TO THE FOURTH DISTRICT COURT OF APPEAL OF FLORIDA

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The Daily Record Co., Baltimore, MD 21202

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APPENDIX A

IN THE DISTRICT COURT OF APPEAL OF THE STATE OF FLORIDA FOURTH DISTRICT
JANUARY TERM 1989

BLUE CROSS/BLUE SHIELD OF FLORIDA, INC.,

Appellant,

v.

ROBERT WEINER, MARGARET WEINER, MARK WEINER and ROBERT WEINER as Personal Representative of the Estate of STEVEN WEINER, BLUE CROSS OF MARYLAND, INC., BLUE SHIELD OF MARYLAND, INC., BLUE CROSS AND BLUE SHIELD OF MARYLAND, INC.,

Appellees.

NOT FINAL UNTIL TIME EXPIRES TO FILE REHEARING MOTION AND, IF FILED, DISPOSED OF.

CASE NOS. 4-86-2899
4-86-2924
4-86-2925
4-86-2926
and 4-86-2927.

Opinion filed April 26, 1989

Consolidated appeals from the Circuit Court for Broward County; Robert L. Andrews, Judge.

Alan C. Sundberg and Sylvia Wabolt
of Carlton, Fields, Ward, Emmanuel,
Smith, Cutler & Kent, P.A., Tampa;
Esler & Kirschbaum, P.A., Fort
Lauderdale; Podhurst, Orseck, Parks,
Josefsberg, Eaton, Meadow & Olin,
Miami; for appellant.

Joan Fowler and G. Bart Billbrough
of Walton Lantaff Schroeder & Carson,
West Palm Beach, for Blue Cross/Blue
Shield of Maryland, Inc., Blue Cross
of Maryland, Inc., and Blue Shield
of Maryland, Inc.

Larry S. Stewart and James B. Tilghman,
Jr., of Stewart Tilghman Fox & Bianchi,
P.A., Miami, for Appellees-Weiner.

STONE, J.

This is a consolidated appeal from a final judgment in favor of the Weiners, the insureds, against Blue Cross and Blue Shield of Florida (Florida) and Blue Cross and Blue Shield of Maryland (Maryland). The jury returned a verdict against both companies on claims of fraud and intentional infliction of emotional distress, and against Maryland on negligence as well.

The claims arose out of a denial of coverage by Maryland. Maryland had issued a group health insurance plan which it sold to individual gasoline service station retailers through an independent marketing company, ASFI, supposedly in cooperation with the national and state service station dealers associations. Maryland retained Florida as its agent to service those accounts in this state. Maryland wrote the policies, and prepared a National Account Enrolled Group Summary (NAEGS), which set out guidelines to be followed by the servicing agents in each state in administering the group policy.

The plaintiff joined Service Station Dealers of America and purchased health insurance coverage for his family

through ASFI, which became effective in March 1982. At that time the policy covered his sons, Mark, age 18, and Steven, age 20, who was enrolled as a full-time student. Tragically, on August 21, 1982, Mark, as a result of an accident, became a quadriplegic. During that same summer, Steven was diagnosed as having a fatal illness and did not return to school. Both required hospitalization and extensive nursing care. In August 1983, a decision was made by Maryland, and communicated to plaintiffs through Florida, that Mark was not covered since the accident occurred after his 19th birthday, and that Steven was not covered because he was no longer a full-time student.

In fact, the benefits book prepared by Maryland provided that children were covered until the end of the calendar year in which they turned 19 and that full-time students were covered until the end of the calendar year in which they turned 23. However, the NAEGS provided that, where a 19 year old, or older, child was incapable of self support due to physical incapacity, that child would remain covered, provided the incapacity occurred prior to the child's 19th birthday.

The Weiners' nursing service terminated home care as to both children when they learned that coverage was no longer available. The plaintiffs' attorney contacted Florida and was told that the question of coverage was Maryland's decision. The attorney was referred to a Maryland executive, who advised him that Maryland had terminated coverage. The result was loss and suffering by the family from the lack of nursing care. Florida did offer, and did furnish, a conversion policy as to Mark, which did not include major medical coverage. It did not advise plaintiffs of their right to a conversion policy for Steven.

In October 1983, the Weiners filed suit, alleging the following counts: I.) fraud as to Maryland; II.) fraud as to Florida for falsely representing to the plaintiffs that they needed to purchase a conversion policy for Mark after his 19th birthday; III.) intentional infliction of mental distress as to

both companies; IV.) negligence as to Maryland; and V.) negligence as to Florida. In March 1984, Maryland agreed to reinstate the coverage. The jury found in favor of Florida on the negligence claim and in favor of plaintiffs on all other counts. The verdict against Maryland was for $500,000 compensatory damages and $5,000,000 punitive damages, and against Florida for $200,000 compensatory and $1,500,000 punitive damages.

With respect to the fraud claim, Florida contends that there was no evidence that the conduct of its employees was anything more than negligent. Florida argues that it was entitled to rely upon what it was told by its principal, Maryland, and by ASFI, as it did not have the contract, even if a copy of the booklet was in Florida's possession. We concur, and conclude that Florida was entitled to a directed verdict on the fraud claim. Recovery for fraud requires proof of intentional and knowing misrepresentation of material fact, designed to cause detrimental reliance. *See First Interstate Development Corp. v. Ablanedo,* 511 So.2d 536 (Fla. 1987); *A.S.J. Drugs, Inc. v. Berkowitz,* 459 So.2d 348 (Fla. 4th DCA 1984). As an agent, Florida relayed the decisions of its principal to plaintiffs and their attorney. There was no proof of any intentional misrepresentation or any actual knowledge by Florida that Mark and Steven remained covered by the Maryland policy.

While the failure of Florida to provide broader benefits in the conversion contract may have been negligent, or a breach of contract, there is no proof of fraud. The evidence reflects that even prior to the accident, ASFI, which had no connection to Florida, had advised plaintiffs of the impending expiration of coverage upon Mark's 19th birthday and directed the insured to contact Florida about conversion to a non-group plan for Mark, and that this advice was subsequently repeated to plaintiffs by ASFI. It is further apparent from the record that once Maryland decided to terminate coverage, Florida had a contractual duty to offer the alternative coverage. Thus, the plaintiffs failed to establish that

Florida knew that any of its representations, either as to the need for a conversion policy or as to coverage under either policy, were false.

With respect to the intentional infliction of emotional distress claim against Florida, we also reverse. In *Metropolitan Life Insurance Co. v. McCarson,* 467 So.2d 277 (Fla. 1985), the supreme court applied these comments given in the *Restatement (Second) of Torts,* §46 (1965):

> d. Extreme and outrageous conduct
>
> . . . It has not been enough that the defendant has acted with an intent which is tortious or even criminal, or that he has intended to inflict emotional distress, or even that his conduct has been characterized by "malice," or a degree of aggravation which would entitle the plaintiff to punitive damages for another tort. Liability has been found only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community. Generally, the case is one in which the recitation of the facts to an average member of the community would arouse his resentment against the actor, and lead him to exclaim, "Outrageous!"
>
> . . . .
>
> g. The conduct, although it would otherwise be extreme and outrageous, may be privileged under the circumstances. The actor is never liable, for example, where he has done no more than to insist upon his legal rights in a permissible way, even though he is well aware that such insistence is certain to cause emotional distress.

There, Metropolitan Life issued a group insurance policy to McCarson, which covered employees of his shop, including his wife. Mrs. McCarson became incapacitated the next year with Alzheimer's disease, and the insurer stopped payment of her benefits, claiming her condition was preexisting. McCarson filed suit and Metropolitan Life was found in

breach of contract and ordered to provide coverage. Mrs. McCarson later needed continual nursing care, for which Metropolitan was responsible until the policy lapsed or she became eligible for Medicare. The insurer requested proof of ineligibility for Medicare, and discontinued payment of benefits when it received no response. Looking at the facts in the light most favorable to the plaintiff, the supreme court ruled that they were not, as a matter of law, " 'so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency.' " *McCarson* at 279.

Here, there was no evidence that Florida had the authority to make independent coverage decisions with respect to Maryland's policy, and it initially double checked the coverage question with Maryland. In any event, it is undisputed that, when questioned about the coverage issue, Florida referred plaintiffs' counsel to Maryland, and that all further discussions were between them. The proof simply failed to reach the heavy burden required for recovery on this tort. *See Metropolitan Life Insurance Co. v. McCarson; Swinarski v. Keller,* 529 So.2d 1208 (Fla. 4th DCA 1988); *Davis v. Gulf Life Insurance Co.,* 502 So.2d 1012 (Fla. 3d DCA 1987). *See also Campbell v. Prudential Insurance Co.,* 480 So.2d 666 (Fla. 5th DCA 1985). *Cf. Dominguez v. Equitable Life Assurance Society of the United States,* 438 So.2d 58 (Fla. 3d DCA 1983).

Therefore as to Florida, we conclude that the trial court erred in denying Florida's motion for directed verdict as to the plaintiffs' claims for fraud and intentional infliction of emotional distress, and reverse.

With respect to Maryland, we first find no error in the instruction to the jury that ASFI was an agent of Maryland in connection with the group health plan. Ordinarily the existence of an agency relationship is a question of fact. *Orlando Executive Park, Inc. v. Robbins,* 433 So.2d 491 (Fla. 1983); *Folwell v. Bernard,* 477 So.2d 1060 (Fla. 2d DCA 1985), *rev. denied,* 486 So.2d 595 (Fla. 1986). However, here the relationship between Maryland and ASFI, in the devel-

opment of and the national marketing of the group plan, in distributing Maryland's benefit book, and in other acts pursuant to the agreement between them, is susceptible of only one interpretation. *See Jaar v. University of Miami,* 474 So.2d 239 (Fla. 3d DCA 1985), *rev. denied,* 484 So.2d 10 (Fla. 1986). Therefore, the trial court did not err in concluding as a matter of law that ASFI was acting on Maryland's behalf.

As to Maryland, we are satisfied that there was sufficient evidence in the record, when considering inferences that may be drawn from the proofs, to submit the issue of fraud to the jury. *See U.S. Home Corporation, Rutenberg Homes Division v. Metropolitan Property and Liability Insurance Co.,* 516 So.2d 3 (Fla. 2d DCA 1987); *Needle v. Lowenberg,* 421 So.2d 678 (Fla. 4th DCA 1982), *rev. denied,* 427 So.2d 737 (Fla. 1983); *Nantell v. Lim-Wick Construction Co.,* 228 So.2d 634 (Fla. 4th DCA 1969). *Cf. Sun Life Assurance Company of Canada v. Land Concepts, Inc.,* 435 So.2d 862 (Fla. 4th DCA 1983); *First National Bank of Stuart v. Jackson,* 267 So.2d 697 (Fla. 4th DCA 1972). We also find no error in submitting the issue of punitive damages to the jury. *First Interstate Development Corp. v. Ablenado,* 511 So.2d 536 (Fla. 1987); *Rappaport v. Jimmy Bryan Toyota of Fort Lauderdale, Inc.,* 522 So.2d 1005 (Fla. 4th DCA 1988); *Ruding v. Thompson,* 517 So.2d 706 (Fla. 4th DCA 1987)

The appellees argue that Maryland's motion for directed verdict on the punitive damage issue did not question the sufficiency of proof on the fraud and emotional distress claims. However, we need not examine this point, nor whether the evidence supports the jury's findings that Maryland's actions amounted to an intentional infliction of emotional distress. The verdict form used here does not contain separate findings for damages for each count pled. As the verdict may be sustained on any one of the theories submitted to the jury, reversal is improper where no error is found as to one of those theories. *See Colonial Stores, Inc. v. Scarbrough,* 355 So.2d 1181 (Fla. 1978); *Florida Patient's Compensation Fund v. Sitomer,* 524 So.2d 671 (Fla. 4th DCA

1988); *Howell v. Woods*, 489 So.2d 154 (Fla. 4th DCA 1986); *Getelman v. Leve* , 481 So.2d 1236 (Fla. 3d DCA 1985).

Maryland's principal assertion on appeal is that there is a lack of jurisdiction over the subject matter because the plaintiff's claim is preempted by the Employee Retirment Income Security Act of 1974, 29 U.S.C. §1001-1461, ("ERISA"), and that state courts do not have concurrent jurisdiction. *See also Pilot Life Insurance Co. v. Dedeau*, 481 U.S. 41, 107 S.Ct. 1549, 95 L. Ed. 2d 39 (1987). However, we find that ERISA does not apply to this policy.

ERISA regulates employee benefit plans, including ones providing for medical and hospital care, if the plan is established or maintained by an employer or employee organization, or both. ERISA §4(a), 29 U.S.C. §1003(a). Here, the record does not support a conclusion that there was an employee plan. The record does not reveal any agreement between the service station dealers associations and Maryland or AFSI. The evidence, although disputed, reflects that the plaintiff here was a sole proprietor who simply purchased a group policy for his family. *See Xaros v. U.S. Fidelity and Guaranty Co.*, 820 F. 2d 1176 (11th Cir. 1987); *Donovan v. Dillingham*, 688 F. 2d 1367 (11th Cir. 1982); *Taggart Corp. v. Life and Health Benefits Administration, Inc.*, 617 F. 2d 1208 (5th Cir. 1980). Here there was no plan, or even an informal agreement, established or maintained by an employer or an employee organization. Nor were any fiduciary responsibilities created by this insurance marketing scheme, which simply made group insurance available to members of the organization.

Maryland contends that attorney's fees were improperly taxed under section 627.428, Florida Statutes. However, it appears that this action involved additional issues other than those presented on appeal regarding the plaintiffs' tort claims. The trial court found that matters of coverage and interpretation of the policy were the "central core" of the trial. The trial court acknowledged that the sums sought and amount of hours appeared large, but were in part neces-

sitated by obstructionist tactics. Generally claimants are not entitled to attorney's fees under section 627.428 in a tort action. *E.g., United General Life Insurance Co. v. Koske,* 519 So.2d 71 (Fla. 5th DCA 1988); *United Services Automobile Association v. Kiibler,* 364 So.2d 57 (Fla. 3d DCA 1978). However, the trial court determined that this award was founded on the hours utilized in resolving coverage. Nor has Maryland shown that the amount of the fee was clearly excessive. *See Good Samaritan Hospital Ass'n v. Saylor,* 495 So.2d 782 (Fla. 4th DCA 1986). *See also State Farm Fire & Casualty Co. v. Palma,* 524 So.2d 1035 (Fla. 4th DCA 1988).

As we are reversing the judgment against Florida, the award of attorney's fees in favor of the insured must be reversed as to Florida. We therefore reverse the judgment of attorney's fees and remand in order that they may be reapportioned as to Maryland alone.

We find the other issues raised by Maryland also to be without merit. Therefore, the final judgment is affirmed as to Maryland and reversed as to Florida. We remand so that an amended judgment against Maryland may be entered accordingly.

DOWNEY and LETTS, JJ., concur.

APPENDIX B

IN THE DISTRICT COURT OF APPEAL OF THE
STATE OF FLORIDA FOURTH DISTRICT,
P.O. BOX A, WEST PALM BEACH, FL 33402

BLUE CROSS/BLUE SHIELD
OF FLORIDA, INC.,

Appellant(s),

v.

ROBERT WEINER,
MARGARET WEINER, et al.,

Appellee(s).

CASE NO. 4-86-2899, 4-86-2924
4-86-2925, 4-86-2926
and 4-86-2927.

JUNE 19, 1989

BY ORDER OF THE COURT:

ORDERED that the May 11, 1989 Motion for Rehearing and Rehearing *en banc*, filed by Blue Cross of Maryland, Inc., is hereby denied.

I hereby certify that the foregoing is a
true copy of the original court order.

/s/

CLYDE L. HEATH,
CLERK.

cc: G. Bart Billbrough
Larry S. Stewart
Joel L. Kirschbaum
Bob Josephsberg
Alan C. Sundberg–

cms

APPENDIX C

IN THE CIRCUIT COURT OF THE
17TH JUDICIAL CIRCUIT IN AND
FOR BROWARD COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO.: 84-00840 CH

ROBERT WEINER, MARGARET WEINER,
MARK WEINER, and ROBERT WEINER
as Personal Representative of
the Estate of STEVEN WEINER,

Plaintiffs,

vs.

BLUE CROSS OF MARYLAND, INC.,
BLUE SHIELD OF MARYLAND, INC.,
BLUE CROSS and BLUE SHIELD OF
MARYLAND, INC. and BLUE CROSS/
BLUE SHIELD OF FLORIDA, INC.,

Defendants

FINAL JUDGMENT

THIS CAUSE came on to be heard before the Honorable Robert L. Andrews, one of the Judges of the above-styled Court, and a jury of six true and lawful men and women, who, having been first duly sworn according to law, and having heard the evidence, the arguments of counsel and the charges of the Court, and having retired to consider their verdict, returned in open Court the following verdict, to-wit:

We, the jury, return the following verdict:

1. Did Blue Cross/Blue Shield of Maryland misrepresent the coverage available under its group health plan for Mark or Steven Weiner, which was a legal

cause of injury to the plaintiffs?

YES X NO ___

2. Did Blue Cross/Blue Shield of Florida misrepresent the need for or terms of continuing coverage for Mark Weiner, which was a legal cause of injury to the plaintiffs?

YES X NO ___

3. Were there intentional or reckless actions of either Blue Cross/Blue Shield of Maryland or Blue Cross/Blue Shield of Florida that caused severe emotional distress to the plaintiffs?

As to Blue Cross/Blue Shield of Maryland:
YES X NO ___

As to Blue Cross/Blue Shield of Florida:
YES X NO ___

4. Was there negligence on the part of either Blue Cross/Blue Shield of Maryland or Blue Cross/ Blue Shield of Florida in the administration of the group health plan which was a legal cause of damage to the plaintiffs?

As to Blue Cross/Blue Shield of Maryland:
YES X NO ___

As to Blue Cross/Blue Shield of Florida:
YES ___ NO X

[If you have answered NO to questions l, 2, 3 and 4, your verdict is for the defendants and you should not proceed further except to date and sign this verdict form and return it to the courtroom. If., however, your answer to any part of any one or more of questions 1, 2, 3 or 4 is YES, you should proceed to answer question 5.

5. What is the total amount (100%) of the injury or damages sustained by each of the plaintiffs by virtue

of the defendant and/or defendants' acts?

	As to Blue Cross/Blue Shield of Maryland	As to Blue Cross/Blue Shield of Florida
Robert Weiner	$100,000.00	$50,000.00
Margaret Weiner	$100,000.00	$50,000.00
Mark Weiner	$150,000.00	$50,000.00
Estate of Steven Weiner	$150,000.00	$50,000.00

[If your answer to any part of any one or more of questions 1, 2 or 3 is YES, you should also proceed to answer question 6.]

6. As punitive damages against the defendants, the jury assesses the following sums:

Blue Cross/Blue Shield of Maryland	$5,000,000.00
Blue Cross/Blue Shield of Florida	$1,500,000.00

SO SAY WE ALL this 25th day of September, 1986.

/s/ Willie Woods
Foreperson

it is therefore

ORDERED AND ADJUDGED that Final Judgment be and it it [sic] hereby entered in this cause in favor of the plaintiffs and against the defendants, and the plaintiff, Robert Weiner, shall have and recover from the defendant, Blue Cross/Blue Shield of Maryland, the sum of One Hundred Thousand Dollars ($100,000.00) and from the defendant, Blue Cross/Blue Shield of Florida, the sum of Fifty Thousand Dollars ($50,000.00), lawful money of the United States of America; the plaintiff, Margaret Weiner, shall have and recover from the defendant, Blue Cross/Blue Shield of Maryland, the sum of One Hundred Thousand Dollars

($100,000.00) and from the defendant, Blue Cross/Blue Shield of Florida, the sum of Fifty Thousand Dollars ($50,000.00), lawful money of the United States of America; the plaintiff, Mark Weiner, shall have and recover from the defendant, Blue Cross/Blue Shield of Maryland, the sum of One Hundred Fifty Thousand Dollars ($150,000.00) and from the defendant, Blue Cross/Blue Shield of Florida, the sum of Fifty Thousand Dollars ($50,000.00), lawful money of the United States of America; the plaintiff, the Estate of Steven Weiner, shall have and recover from the defendant, Blue Cross/Blue Shield of Maryland, the sum of One Hundred Fifty Thousand Dollars ($150,000.00) and from the defendant, Blue Cross/Blue Shield of Florida, the sum of Fifty Thousand Dollars ($50,000.00), lawful money of the United States of America; and the plaintiffs shall recover as punitive damages from the defendant, Blue Cross/Blue Shield of Maryland, the sum of Five Million Dollars ($5,000,000.00) and as punitive damages from the defendant, Blue Cross/Blue Shield of Florida, the sum of One Million, Five Hundred Thousand Dollars ($1,500,000.00), lawful money of the United States of America; and FOR WHICH LET EXECUTION ISSUE.

IT IS FURTHER ORDERED AND ADJUDGED that the Court shall retain jurisdiction of this cause and the parties thereto for determination of the question of taxation of costs and attorneys fees.

DONE AND ORDERED in Chambers at Fort Lauderdale, Broward County, Florida, this 26th day of September, 1986.

/s/

CIRCUIT COURT JUDGE

Copies furnished to:
Stewart Tilghman Fox & Bianchi, P.A.
Esler & Kirschbaum
Walton Lantaff Schroeder & Carson
Podhurst Orseck Parks Josefsberg
Eaton Meadow & Olin

APPENDIX D

IN THE CIRCUIT COURT OF THE
17TH JUDICIAL CIRCUIT IN AND
FOR BROWARD COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO.: 84-00840 CH

ROBERT WEINER, MARGARET WEINER,
MARK WEINER, and ROBERT WEINER
as Personal Representative of
the Estate of STEVEN WEINER,

Plaintiffs,

vs.

BLUE CROSS OF MARYLAND, INC.,
BLUE SHIELD OF MARYLAND, INC.,
BLUE CROSS and BLUE SHIELD OF
MARYLAND, INC. and BLUE CROSS/
BLUE SHIELD OF FLORIDA, INC.,

Defendants.

ORDER ON PLAINTIFFS' MOTION FOR ATTORNEYS' FEES AND JUDGMENT THEREON

THIS CAUSE coming on before the Court on November 20, 1986, on the Plaintiffs' Motion for Attorneys Fees and the Court having conducted a hearing and considered the testimony and evidence presented at such hearing, and the Court being fully advised in the premises, hereby makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. The Court finds that the matters of coverage, interpretation of the insurance policies involved and the policy claims of the defendants were the mainstay of contention

and the central core of the trial of this case and of much of the discovery and pretrial proceedings that preceded the trial. The Court has carefully examined the time itemizations submitted on behalf of plaintiffs' counsel and has specifically excluded time involved in travel as well as time that the Court has found to be duplicative. The Court has also specifically excluded over 500 hours of paralegal time in accordance with the holding in *Rivers Trailers, Inc. v. Miller,* 489 So.2d 1139 (Fla. lst DCA 1986).

Taking all of the foregoing into account, the Court finds that the reasonable amount of hours expended by plaintiffs' counsel in this case with respect to the matters of coverage, interpretation of the insurance policies involved and the policy claims of the defendants is as follows:

Colson, Hicks & Ridson	158.5
Larry S. Stewart	800.0
David W. Bianchi	900.0

In arriving at these figures, the Court has considered the fact that the insurance benefits resulting to the plaintiffs by reason of this action, may well exceed several million dollars. At the time that the defendants began to process plaintiffs bills in March, 1984, there was outstanding approximately $150,000 in unpaid medical bills. During the progress of the litigation, the defendants asserted that the entire coverage was void by reason of plaintiffs' misrepresentation and that alternatively certain services were not covered benefits. The insurance coverage consists of three policies: physician services coverage in an unlimited amount, hospital services coverage in an unlimited amount and major medical coverage with a primary limit of $1,000,000 per person. The plaintiff, Mark Weiner, is a quadriplegic and will undoubtedly require medical care in excess of $1,000,000. The plaintiffs, Robert and Margaret Weiner, have in the past and most probably will in the future require medical care.

The Court also notes that while these amounts of time in the abstract appear large, the Court finds that a great deal

of this time was necessitated by the defendants' conduct in pursuing obstructionist discovery tactics, asserting non-meritorious policy positions and a non-meritorious affirmative defense all of which resulted in extensive discovery which would otherwise have been unnecessary. Consistent with the purpose of Chapter 627.428, Florida Statutes, to discourage contesting of insurance matters, the Court finds that all of such time expended by plaintiffs' counsel in dealing with those matters should be included in arriving at a reasonable fee. The Court also notes with respect to the reasonableness of the time involved by plaintiffs' counsel, that the defense attorneys in this case cumulatively spent in excess of 2800 hours. Although that time included all issues, it strongly buttresses the reasonableness of plaintiffs' counsels' time on the insurance issues.

2. In arriving at a reasonable hourly rate, the Court has taken into account the skill and expertise of the counsel involved as well as the testimony of the expert witnesses. The Court finds that a reasonable hourly rate for Larry S. Stewart is $350 per hour; that a reasonable hourly rate for David W. Bianchi is $200 per hour; and that a reasonable hourly rate for the time of the firm of Colson, Hicks & Ridson, which consists primarily of the services of Dean Colson, is $200 per hour.

3. Based on the foregoing the Court determines that the lodestar for Larry S. Stewart is Two hundred eighty thousand Dollars ($280,000.00); that the lodestar for David W. Bianchi is One hundred eighty thousand Dollars ($180,000.00); and that the lodestar for Colson, Hicks & Ridson is Thirty-one thousand, six hundred Dollars ($31,600.00).

4. In consideration of the expert witness testimony and the Court's own personal observation of the trial of this cause, the Court finds that there should be an upward enhancement based upon the "contingency risk factor" delineated in *Florida Patients Compensation Fund v. Rowe*, 472 So.2d 1145 (Fla. 1985). Based on the Court's observa-

tions of the file, pretrial hearings and the trial itself, the Court finds that the likelihood of success at the time the case was initiated was unlikely. From the very outset, up to the trial itself, the defendants took the position of stonewalling, of delaying and going into collateral matters to divert the search for the truth. In the hands of lesser counsel there would in all probability have been no success at all. The unlikelihood of success is also borne out in part by the fact that Blue Cross/Blue Shield of Maryland never made any offer of settlement and Blue Cross/Blue Shield of Florida stated it would consider only a minimal offer of settlement before trial. Based on the foregoing, the Court finds that as to the services performed by Larry S. Stewart and David W. Bianchi, the lodestar should be enhanced by a multiplier of 3.0. As to the services of Colson, Hicks & Ridson, the Court does not find a multiplier to be applicable.

5. Multiplying the lodestar figure for the services of Larry S. Stewart and David W. Bianchi by 3.0 and including the lodestar for Colson, Hicks & Ridson, the Court determines the reasonable attorneys' fee in this case to be One Million, Four Hundred Eleven Thousand, Six Hundred Dollars ($1,411,600.00).

CONCLUSIONS OF LAW

Based upon the foregoing, it is hereby

ORDERED AND ADJUDGED that the Plaintiffs [sic] Motion for Attorneys Fees be and the same hereby is granted and attorneys fees are hereby awarded to the plaintiffs in the sum of One Million, Four Hundred Eleven Thousand, Six Hundred Dollars ($1,411,600.00).

JUDGMENT ON ATTORNEYS FEES

It is hereby ORDERED AND ADJUDGED that a judgment of attorneys fees be entered in favor of the Plaintiffs, Robert Weiner, Margaret Weiner, Mark Weiner, and Robert Weiner as Personal Representative of the Estate of Steven Weiner, and against the Defendants, Blue Cross of Mary-

land, Inc., Blue Shield of Maryland, Inc., Blue Cross and Blue Shield of Maryland, Inc. and Blue Cross/Blue Shield of Florida, Inc., and the Plaintiffs shall have and recover as attorneys fees from said Defendants the sum of One Million, Four Hundred Eleven Thousand, Six Hundred Dollars ($1,411,600.00), lawful money of the United States of America, and for which let execution issue.

DONE AND ORDERED in Chambers Fort Lauderdale, Broward County, Florida this 24th day of November, 1986.

/s/

CIRCUIT COURT JUDGE

Copies furnished to:

Mr. Carl E. Jenkins
WALTON LANTAFF SCHROEDER & CARSON
Robert C. Josefsberg
PODHURST ORSECK PARKS JOSEFSBERG
EATON MEADOW & OLIN, P.A.
Joel L. Kirschbaum
ESLER & KIRSCHBAUM, P.A.
Larry S. Stewart
STEWART TILGHMAN FOX & BIANCHI, P.A.

APPENDIX E

IN THE CIRCUIT COURT OF
THE 17TH JUDICIAL CIRCUIT
IN AND FOR BROWARD COUNTY,
FLORIDA

GENERAL JURISDICTION
DIVISION

CASE NO.: 84-00840 CH

ROBERT WEINER, MARGARET WEINER,
MARK WEINER, and ROBERT WEINER
as personal representative of
the estate of STEVEN WEINER,

Plaintiffs,

vs.

BLUE CROSS OF MARYLAND, INC.,
BLUE SHIELD OF MARYLAND, INC.,
BLUE CROSS and BLUE SHIELD OF
MARYLAND, INC.

Defendants.

ORDER ON PLAINTIFFS' MOTION FOR ATTORNEYS FEES BY REMAND FROM THE 4TH DISTRICT COURT OF APPEAL

THIS CAUSE is before the Court on remand from the 4th District Court of Appeal, following an appeal by the Defendants, regarding an award of attorney fees in favor of the Plaintiff. In that appeal, the Court reversed the judgement of attorney fees against Florida, and remanded so that this Court may reapportion attorney fees as to Maryland alone.

FINDINGS OF FACT

The facts of this case are as follows. In March of 1982, Mr. Weiner purchased health insurance for himself and his family. That policy was sponsored by Blue Cross/Blue Shield of Maryland (Maryland). Blue Cross/Blue Shield of Florida (Florida) was at all times Maryland's agent for the purpose of servicing claims arising in this state.[1] Tragically, in August [19]82, Mark Weiner was involved in an accident and became a quadriplegic. That same summer Steven Weiner was diagnosed with a fatal illness. As the insurance coverage called for, Maryland began making payments for hospitalization and nursing care. In August of 1983, Mr. Weiner was informed that all coverage was being terminated. When negotiations to reinstate coverage proved fruitless, a suit was instituted in which Mr. Weiner prevailed against both Defendants. This Court, on plaintiff's motion, then awarded the Weiners attorney's fees as called for by Florida Statute 627.428.[2] Florida appealed to the 4th District Court of Appeal which reversed both the judgment and the award of attorney's fees as to Florida but affirmed the judgment as to Maryland. It is now this Court's responsibility to consider the issue of reapportionment of the award of attorney's fees as to Maryland alone.

The issues surrounding attorney fees have seen ample exposure in this State. It is well settled in Florida that attorney's fees may only be awarded by contract, when an attor-

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[1] The 4th District Court of Appeal itself expressly noted that Florida was Maryland's agent.

[2] Florida Statute 627.428 Attorney's Fees

(1) Upon the rendition of a judgment of decree by any of the courts of this state against an insured and in favor of any named or omnibus insured . . . the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which recovery is had.

ney creates or brings a special fund into the court, or as in this case, by statute. *McElhiney v. Ash Properties, Inc.*, 411 So.2d 291 (Fla. lst Dist. Ct. App. 1982), *City of Miami Beach v. Town of Bay Harbor Islands*, 380 So.2d 1112 (Fla. 3rd Dist. Ct. App. 1980). The remedy stated in Florida Statute 627.428 has existed in some form or another for many years. The aim of this statute, and the underlying public policy is to dissuade insurers from contesting insurance coverage, especially when the insureds, such as the plaintiffs, are in such dire straits. *Feller v. Equitable Life Assurance Soc.*, 57 So.2d 581,586 (Fla. 1952) (en banc), *Florida Rock and Tank Lines, Inc. v. Continental Insurance Co.*, 399 So.2d 122,124 (Fla. lst Dist. Ct. App. 1981). In cases such as these, the statutory provisions awarding attorney's fees is in the nature of a penalty, and must be strictly construed by the court. *Wilmington Trust Co. v. Manufacturers Life Insurance*, 749 F.2d 694, 700 (11th Cir. 1985), *Travelers Indemnity Co. v. Chisholm*, 384 So.2d 1360 (Fla. 2d Dist. Ct. App. 1980), *American National Insurance Co. v. de Cardenas*, 181 So.2d 359, 361 (Fla. 3rd Dist. Ct. App. 1965).

It is Maryland's position that time expended by Plaintiff's attorneys in relation to Florida should not be assessed against them. To support this position Maryland cites *Vulcan Socieity [sic] of Westchester Cty. v. Fire Department*, 533 F. Supp. 1054 (S.D.N.Y. 1982). That case states that when certain aspects of litigation are attributable solely to one or more defendants, that fairness requires those matters to be identified, and divided among *only responsible* defendants. *Id at 1064*. What the Defendants overlook is that they and not Florida were solely responsible for the Plaintiff's insurance coverage being canceled. It was for this exact reason that the Court of Appeal reversed the judgement as to Florida. It is also for this reason that attorney fees accumulated by the plaintiffs concerning their insurance coverage should be paid by Maryland.

Strictly construing the language of Florida Statute 627.428 gives guidance to the Court in awarding a prevail-

ing insured attorney's fees in a suit involving coverage issues. The statute does not call for apportionment of attorneys fees between two insurers who caused a suit regarding coverage to be instituted. The Statute does however impliedly call for the apportionment of attorneys fees when there are other claims in a suit besides the interpretation of the policy and the determination of coverage, but that is not the case here. In this case, the issues involved fall squarely within the scope and public policy of Florida Statute 627.428.

Maryland also cites *Nash v. Chandler,* 848 F.2d 567 (5th Cir. 1988) for the proposition that fees expended for unsuccessful claims should be segregated from the fee award against Maryland. However, the Court in *Nash* ultimately found that "[t]he unsuccessful claims were not so distinct from the successful claims as to be severed for the purpose of awarding attorney fees". *Id at 572.* In the present case, the claims presented against both Defendants were identical, and all arose from the insurance coverage sponsored by Maryland. Had the claims against the Defendants been separate and distinct then the fee award would properly be divided among those claims, but this is not the case.

Both the Trial Court and Court of Appeal held that matters of coverage and interpretation of the insurance policy were the "central core" of the trial. The United States Supreme Court with reference to a civil rights case has held that:

> [i]n some cases a plaintiff may present in one lawsuit distinctly different claims for relief that are based on different facts and legal theories. In such a suit, even where the claims are brought against the same defendants . . . counsel's work on one claim will be unrelated to his work on another claim. Accordingly, work on an unsuccessful claim cannot be deemed to have been "expended in pursuit of the ultimate result achieved" . . . It may well be that cases involving such unrelated claims are unlikely to arise with great frequency. . . . In other cases the plaintiff's claims for

> relief will involve a common core of facts or will be based on related legal theories. Much of counsel's time will be devoted generally to the litigation as a whole, making it difficult to divide the hours expended on a claim-by-claim basis. Such a lawsuit cannot be viewed as a series of discrete claims. Instead the district court should focus on the significance of the overall relief obtained by the plaintiff in relation to the hours reasonably expended on the litigation."

Hensley v. Eckerhart, 103 S.Ct. 1933, 1940, 461 U.S. 424, 435 (1983).

The theories above are aptly summarized in *Chrysler Corp. v. Weinstein,* 522 So.2d 895 (Fla. 3rd Dist. Ct. App. 1988). That case as in the instant one had two defendants and one plaintiff. In *Weinstein* the Appellate Court states "[W]hen claims arose from the same common core of facts the apportionment between claims is not necessary". The Court in *Weinstein* felt that if separate and distinct causes of actions are present rather than alternative theories of liability, apportionment would be appropriate. In this case, every cause of action raised against Maryland was properly raised against Florida. This was due to the tactics of the Defendants in both the initial discovery and pretrial proceedings.[3] It was not until after formal proceedings began that this Court could have concluded that Florida was merely acting as an agent for the benefit of Maryland. It is for reasons such as these that the judgment of attorney fees should be assessed against Maryland alone.

The other cases cited by Maryland are also inapplicable since they involve apportionment between several defen-

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[3] The tactics used by Maryland and Florida resulted in liability for the infliction of emotional distress. Florida was relieved from liability by the 4th District Court of Appeal because the Court found that as an agent, Florida only relayed the decisions of its principle (Maryland). The judgement against Maryland along with liability for fraud is now final.

dants and isolated causes of action not all of which allow the prevailing party attorneys fees.

It is Maryland's contention that this court reconsider the entire issue of attorney's fees as if the previous proceedings never occurred. This view however is inconsistent with Florida case law, and would serve only to further tax an already overworked judicial system. This Court has already conducted hearings, considered testimony, and examined evidence concerning the award of attorneys fees, as required by *Florida Patient's Compensation Fund v. Rowe,* 472 So.2d 1145 (Fla. 1985). This Court has also considered those factors set forth in *Rowe* and in its discretion, found that the circumstances made the $1,411,600.00 assessment of attorneys fees reasonable. In addition, the amount of the assessment was not found to be unreasonable, and has been upheld.

CONCLUSIONS OF LAW

For the reasoning demonstrated above the Plaintiffs Motion for Attorneys Fees is hereby granted against Maryland alone.

JUDGEMENT ON ATTORNEY FEES

It is hereby ORDERED AND ADJUDGED that a judgement of attorneys fees be entered in favor of the Plaintiffs Robert Weiner, Margaret Weiner, Mark Weiner, and Robert Weiner as Personal Representative of the Estate of Steven Weiner, against BLUE CROSS OF MARYLAND, INC., BLUE SHIELD OF MARYLAND, INC., BLUE CROSS and BLUE SHIELD OF MARYLAND, INC., and the Plaintiffs shall have and recover as attorneys fees from said Defendant the sum of One Million, Four Hundred Eleven Thousand, and Six Hundred Dollars ($1,411,600.00), lawful money of the United States of America, and for which let execution issue.

DONE AND ORDERED in Chambers Fort Lauderdale, Broward County, Florida this 31st day of July 1989.

/s/
CIRCUIT COURT JUDGE

Copies Furnished to:

Larry S. Stewart
STEWART TILGHMAN FOX & BIANCHI, P.A.
G. Bart Billbrough
WALTON LANTAFF SCHRODER & CARLSON
Joel L. Kirschenbaum
ESLER & KIRSCHBAUM, P.A.
Robert C. Josefsberg
PODHURST ORSECK PARKS JOSEFSBERG
EATON MEADOW & OLIN, P.A.
Alan C. Sundberg and Sylvia H. Walbolt
CARLTON, FIELDS, WARD, EMMANUEL,
SMITH, CUTLER & KENT, P.A.

APPENDIX F

SUPREME COURT OF FLORIDA

Tuesday, October 24, 1989

BLUE CROSS OF MARYLAND, INC., ET AL.,

Petitioners,

v.

ROBERT L. WEINER, ET AL.,

Respondents.

CASE NO.: 74,460

District Court of Appeal,

Fourth District No. 4-86-2899,
4-86-2924, 4-86-2925
4-86-2926, 4-86-2927

This cause having heretofore been submitted to the Court on jurisdictional briefs and portions of the record deemed necessary to reflect jurisdiction under Article V, Section 3(b), Florida Constitution (1980), and the Court having determined that it should decline to accept jurisdiction, it is ordered that the Petition for Review is denied.

No Motion for Rehearing will be entertained by the Court. See Fla. R. App. p. 9.330(d).

OVERTON, Acting C.J.,
SEAW, GRIMES and KOGAN, JJ. concur
McDONALD, J., dissents

A True Copy

TEST: (seal)
Sid J. White /s/
Clerk Supreme Court

cc: Hon. Clyde L. Heath, Clerk
Hon. Robert E. Lockwood, Clerk
Hon. Robert L. Andrews, Judge

G. Bart Billbrough, Esquire
Larry S. Stewart, Esquire
James B. Tilghman, Jr., Esq

APPENDIX G

Pursuant to Rule 28.1, following are the corporate affiliates of Blue Cross and Blue Shield of Maryland, Inc.:

Blue Cross and Blue Shield of Maryland
Finance Company, Inc.
Employers Compliance Services, Inc.
Sterling Health Services, Inc.
Maryland Medical Services, Inc.
DBG Holdings, Inc.
Community Health Services, Inc.
Free State Health Plan, Inc.
Healthline, Inc.
PerTek, Inc.
Benefit Services International, Inc.
Free State Management, Inc.
LifeCard, Inc.
Columbia Medical Plan, Inc.
Health Management Corporation, Inc.
Willse and Associates, Inc.
Columbia Free State Management, Inc.
Twin Knolls Pharmacy, Inc.
Patuxent Medical Group, Inc.
Columbia Dental Plan, Inc.
Patuxent Surgicare, Inc.
Greenspring Mental Health Services, Inc.
Judgment Process Company, Inc.
Columbia Optical Management, Inc.

No. 89-1150

In The

Supreme Court of the United States

October Term, 1989

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.,

Petitioner,

v.

ROBERT WEINER, SR., MARGARET WEINER,
MARK WEINER, and ROBERT WEINER, SR.,
as Personal Representative of the Estate of Steven Weiner,

Respondents.

**On Petition For A Writ Of Certiorari
To The District Court Of Appeal Of Florida,
Fourth District**

RESPONDENTS' BRIEF IN OPPOSITION

LARRY S. STEWART
Counsel of Record
JAMES B. TILGHMAN, JR.
STEWART TILGHMAN FOX &
BIANCHI, P.A.
44 West Flagler St.
Suite 1900
Miami, Florida 33130
(305) 358-6644

Attorneys for Respondents

February 21, 1990

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED FOR REVIEW

Whether the District Court of Appeal of Florida, Fourth District, erred in holding that no employee benefit plan exists where no plan was established or maintained by an employer or employee organization for the purpose of providing benefits to employees.

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TABLE OF AUTHORITIES – Continued

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OTHER AUTHORITIES

No. 89-1150

In The

Supreme Court of the United States

October Term, 1989

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.,

Petitioner,

v.

ROBERT WEINER, SR., MARGARET WEINER,
MARK WEINER, and ROBERT WEINER, SR.,
as Personal Representative of the Estate of Steven Weiner,

Respondents.

**On Petition For A Writ Of Certiorari
To The District Court Of Appeal Of Florida,
Fourth District**

RESPONDENTS' BRIEF IN OPPOSITION

STATEMENT OF THE CASE

Petitioner, Blue Cross and Blue Shield of Maryland, Inc. ("BCBSM"), introduces the decision below as one in which the District Court of Appeal of Florida, Fourth District ("Florida appellate court"), sanctions state tort claims involving employee benefit plans, thereby threatening the very existence of thousands of plans by stripping them of the protection afforded by the Employee

Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 *et seq.* The issue below, however, was not whether state tort claims involving employee benefit plans should be sanctioned, but whether an employee benefit plan existed at all. The reality of the Florida appellate court's decision is that it simply applies an established federal principle – that an employee benefit plan exists only if it is established or maintained by an employer or employee organization to provide benefits to employees – to the unique facts of this case. As those facts demonstrate, the decision below does not speak to thousands of employee benefit plans, but only to the question of whether one existed in connection with the purchase of health insurance by Respondent Robert Weiner, Sr.

In 1982, Mr. Weiner purchased health insurance for his family from BCBSM. That summer, one of his sons, Respondent Mark Weiner, became a quadriplegic in a fall. At about the same time another son, Steve, became ill and was diagnosed as having AIDS. Steve would also become paralyzed before he died.

The boys' health care needs were staggering, but for almost a year they were met with BCBSM's coverage. Then in 1983 BCBSM terminated both boys' insurance. The termination was predicated upon fabricated coverage defenses, and upon terms contained in the master policies which were intentionally more restrictive than the coverage representations BCBSM made in the benefits book it provided the Weiner family (collectively "Weiners") when the policy was sold. Without insurance coverage,

the family subsisted in a trailer with Mr. and Mrs. Weiner trying to give round-the-clock care to their two paralyzed sons, one dying. The ordeal they went through cannot, and fortunately need not, be described in the limited space available here.

In 1984, the Weiners filed suit against BCBSM and its servicing agent, Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), in Florida state court. After more than two years of discovery the case went to trial on the Weiners' claims of fraud, intentional infliction of emotional distress and negligence. The jury returned separate verdicts against both BCBSM and BCBSF, finding against BCBSM on all counts. Final judgments were entered by the Florida trial court in the fall of 1986. The issue of ERISA preemption was never raised.

BCBSM appealed the state trial court judgment to the Florida appellate court in 1987. For the first time, BCBSM contended that the Florida courts lacked subject matter jurisdiction because the Weiners' tort claims were based upon the improper processing of claims for benefits under an employee benefit plan, and thus were preempted by ERISA. BCBSM specifically asked the Florida appellate court to decide the issue on the record before it.

In April of 1988, some 18 days before oral argument was to take place in the Florida appellate court, BCBSM filed an action for declaratory and injunctive relief and a motion for preliminary injunction in the United States District Court for the Southern District of Florida. BCBSM asked the district court to declare the Florida state court

judgment void and unenforceable, and to temporarily and permanently enjoin the Weiners from taking any further action in the Florida appellate court – all on the basis of the same ERISA preemption arguments it makes before this Court.

The district court afforded BCBSM an emergency hearing, received extensive memoranda, and denied the motion for preliminary injunction. In addition, the district court abstained. Abstention is inappropriate in the face of a claim of federal preemption that is plain, obvious or readily apparent, *see, e.g., Fresh Int'l Corp. v. Agricultural Labor Relations Bd.*, 805 F.2d 1353 (9th Cir. 1986); *Baggett v. Department of Professional Regulation Bd. of Pilot Comm'rs*, 717 F.2d 521 (11th Cir. 1983); *Aluminum Co. of America v. Utilities Comm'n of North Carolina*, 713 F.2d 1024 (4th Cir. 1983), *cert. denied*, 465 U.S. 1052 (1984), but the district court found on the evidence before it that ERISA preemption was "a far cry from being 'readily apparent' ".

BCBSM appealed the district court's decision to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit affirmed the district court's decision to abstain, and ordered the case dismissed for lack of subject matter jurisdiction based in part upon a finding that the "Florida appellate court is an appropriate forum for determining whether the state trial court had jurisdiction. . . ." *Blue Cross and Blue Shield of Maryland, Inc. v. Weiner*, 868 F.2d 1550, 1555-1556 (11th Cir.), *cert. denied*,

___ U.S. ___ (October 10, 1989).[1] The Florida appellate court decision was before the Eleventh Circuit when it denied BCBSM's suggestion for rehearing in banc.

BCBSM petitioned this Court for a writ of certiorari to the Eleventh Circuit in August of 1989. In addition to the procedural questions involved, BCBSM and the Weiners joined issue on the same question BCBSM now presents – whether there was an ERISA plan. This Court denied the petition for writ of certiorari on October 10, 1989.

The Florida appellate court, which was never informed of the attempt to halt its deliberations in federal court, rendered its decision on April 26, 1989. BCBSM's position with regard to the existence of an employee benefit plan was different before the Florida appellate court. While it contended then as now that Mr. Weiner or the Weiner service station created an employee benefit plan, at the association of employers level BCBSM contended that the Service Station Dealers of America ("SSDA"), as opposed to the Allied Gasoline Retailers' Association of Florida ("AGRA"), created the plan.

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[1] This decision is in keeping with a wealth of federal decisions holding that state courts are competent and appropriate forums to decide whether ERISA plans and ERISA preemption exist. *See, e.g., Transamerica Occidental Life Ins. Co. v. Digregorio*, 811 F.2d 1249, 1255 n.5 (9th Cir. 1987); *Takeda v. Northwestern Nat'l Life Ins. Co.*, 765 F.2d 815, 822 n.10 (9th Cir. 1985); *Johansen v. Employee Benefit Claims, Inc.*, 668 F.Supp. 1294, 1297 (D. Minn. 1987); *Browning Corp. Int'l v. Lee*, 624 F.Supp. 555, 557 (N.D. Tex. 1986).

On the ERISA issues joined in the Florida appellate court, the evidence showed that no employee benefit plans existed in connection with Mr. Weiner's purchase of health insurance. Rather, it showed that BCBSM and Associated Financial Services, Inc. ("AFSI"), an insurance broker, simply created a group insurance policy to sell to a perceived market niche – service station dealers. To this end, three insurance policies, which BCBSM relies upon as setting forth the terms of the plan, were prepared and purportedly entered into between BCBSM and SSDA. (PX. 29, 30, 31).[2] The catch, however, was that SSDA, which arguably would qualify as an association of employers and thus as an employer under ERISA, had nothing to do with the matter. SSDA was never consulted by BCBSM or AFSI about a plan, it never gave them permission to use its name, and its signature was forged on the group policies by the President of AFSI. (R. 2004-2007, 2020-2021, 2038-2039). SSDA's name was simply used as a ruse to make the group policy more marketable. (R. 2042).

Twelve days after the insurance contracts or "plan documents" were forged, an endorsement was issued by BCBSM eliminating SSDA as both the contracting party and the insured group. AFSI, the insurance broker, was substituted in SSDA's place. (PX. 24; R. 1977-78, 2021). Thereafter, the policies or "plan" at issue provided that BCBSM would provide insurance benefits to the

[2] Evidentiary citations are to the record below. "PX" designates the plaintiffs' exhibits introduced at trial, and "R" designates references to the trial transcript or depositions and pleadings which were made part of the record.

employees of AFSI, an insurance broker having nothing to do with service station dealers or their associations, under the stated terms.

As would be expected in this scenario, neither the group insurance policies nor the benefits booklet made any reference to an ERISA plan or to ERISA as the governing body of law. (PX. 1, 29, 30, 31). Further, none of these documents complied with the requirements for a plan description, 29 U.S.C. §1022, and no attempt was made to comply with ERISA's reporting requirements. 29 U.S.C. §§1023, 1024.

Based on these facts, at the association of employers level the Florida appellate court found that "there was no plan, or even an informal agreement, established or maintained by an employer or an employee organization." Rather, the Florida appellate court found just an "insurance marketing scheme". (Appendix A to Petition, p. 8.).

To avoid the effect of the evidence of its own fraud, BCBSM now contends that AGRA, not SSDA, established or maintained the employee benefit plan. But his new position fails to put a better face on it. As with SSDA, AGRA established nothing. There was no agreement between BCBSM and AGRA for the provision of benefits to AGRA members. BCBSM admitted in response to a request for admissions that it never had any insurance contracts with AGRA (PX. 27), and confirmed through trial testimony that its insuring agreements never went beyond those it had with AFSI. (R. 2039-2040). The "plan" thus provided benefits for AFSI's employees, not AGRA members, and neither the insuring agreements nor the

benefits booklet even mentioned AGRA. (PX. 1, 29, 30, 31).

All BCBSM and AFSI were doing was selling insurance directly to service station dealers, with AFSI handling the marketing and administration of the policies. (R. 3036, 7952). AFSI's President confirmed in trial testimony that AFSI was not in any way acting on behalf of AGRA:

> Q. . . . [Y]ou were not, as far as this business was concerned, acting in any capacity as the agent for this state organization, the Florida state organization; were you?
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> A. No.

(R. 1986).

As for BCBSM's alternate position that Mr. Weiner himself created an employee benefit plan when he purchased health insurance, the evidence showed that Mr. Weiner ran a service station in Dania, Florida as a sole proprietor. (R. 5442, 5503). He and his son Robert Weiner, Jr. worked there along with others. (R. 5445, 5504, 5648-5649). He had never provided any health insurance benefits for his employees, but he religiously provided it for his family. (R. 1504-05). Four separate times at trial and in depositions, when ERISA preemption was not an issue, Mr. Weiner was asked about his purpose in purchasing insurance from BCBSM. Each time he responded that it was to provide insurance for his family. (R. 1509, 1525-26, 1627, 5451). No one was covered by the insurance Mr. Weiner purchased from BCBSM other than family members. One of these family members was a son who worked for him, but the son's testimony also makes

it clear that the motivating relationship was familial rather than employer-employee:

> Q. Did there come a time when you purchased a policy of insurance from [BCBSM] through [SSDA]?
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> A. Not personally.
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> Q. You did not?
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> A. No. My father took care of all the insurances.

(R. 6429).

> Q. Do you know who you were insured with prior to your having become insured under the [BCBSM] plan through [SSDA]?
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> A. No, I don't.
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> Q. Did your father take care of those things at that time?
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> A. He took care of the personal insurance, when it came to health insurance, yes.

(R. 6437).

On these facts, the Florida appellate court again found that "there was no plan . . . established or maintained by an employer or an employee organization", noting that Mr. Weiner was "a sole proprietor who simply purchased a group policy for his family". (Appendix A to Petition, p. 8).

Because the Florida appellate court found that no employee benefit plan existed, it rejected BCBSM's ERISA preemption defense. BCBSM sought discretionary review of the Florida appellate court's decision in the Supreme Court of Florida, contending, *inter alia*, that the appellate

court should not have decided the ERISA preemption question without remanding the matter for trial. Review was denied on October 24, 1989.

REASONS FOR DENYING THE WRIT

1. The Decision Below Raises Neither the Issues Nor the Specters Raised in the Petition

In an attempt to enlarge the importance and effect of the Florida appellate court's decision, BCBSM raises issues and specters which are not raised by the decision below.

First, in delineating the Questions Presented for Review, and in introducing both its Statement of the Case and Reasons for Granting the Writ, BCBSM suggests that the decision below sanctions the bringing of common law tort claims based upon the processing of a claim for benefits under an employee benefit plan – claims which this Court held to be preempted by the public policy and Congressional mandates of ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). The decision below, however, issues no such challenge. The Florida appellate court acknowledged the controlling precedent of *Pilot Life*, declining to find ERISA preemption only because it found that no ERISA plan existed. Needless to say, there is no authority anywhere suggesting a contrary rule.

Second, BCBSM suggests that the Florida appellate court ignored established federal precedent. To the contrary, established federal law was the cornerstone of its opinion. The operative principle of the decision below is that an employee benefit plan exists only if the plan was

established or maintained by an employer for the purpose of providing benefits to employees. This principle comes from both ERISA and the federal decisions. In relevant part Congress defined an employee welfare benefit plan as one "established or maintained by an employer . . . for the purpose of providing [benefits] for its participants or their beneficiaries. . . ." 29 U.S.C. §1002(1). A participant was defined as "any employee . . . of an employer." 29 U.S.C. §1002(7). Congress repeated the first part of this fundamental premise in delineating the scope of ERISA's coverage, providing again that ERISA would apply to "any employee benefit plan if it is established or maintained . . . by an employer." 29 U.S.C. §1003(a)(1).

The message has not been lost on the courts, as evidenced by the Eleventh Circuit's holding that:

> A plan . . . falls within the ambit of ERISA *only* if the plan . . . covers ERISA participants *because of their employee status in an employment relationship, and an employer . . . is the person that establishes or maintains the plan. . . .*

Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982) (emphasis added).

Congress has even re-emphasized the point in response to the phenomenon, present here, of entrepreneurs attempting to characterize their insurance products as ERISA plans:

> [T]hese plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction, nor

- is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisite of the act.

H.R. Rep. No. 1785, 94th Cong., 2nd Sess. 48 (1977), *cited in Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Public Instruction*, 804 F.2d 1059, 1063 (8th Cir. 1986).

The cardinal principle that a plan must be established or maintained by appropriate parties for the appropriate purpose was the Florida appellate court's guide.

Next, BCBSM suggests that the decision below will have far reaching impact because it holds that a small business owned by a sole proprietor cannot establish an ERISA plan – thus "eliminating an entire class of businesses from coverage by ERISA." (Petition p. 20). The Florida appellate court, however, made no such pronouncement. It held that the sole proprietor *in this case* did not establish an employee benefit plan because he "simply purchased a group policy for his family". (Appendix A to Petition, p. 8). For a purchase of insurance to constitute an ERISA plan it must be made for the purpose of providing benefits to employees, 29 U.S.C. §1002(1), (7), or as the Eleventh Circuit put it, to cover participants "because of their employee status in an employment relationship." *Donovan v. Dillingham*, 688 F.2d at 1371; *accord, Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Public Instruction*, 804 F.2d 1059 (no ERISA plan where benefits not provided for statutory purpose). That the purpose necessary to create an employee benefit plan may be lacking when a small businessman purchases insurance for his family has been recognized by the federal courts. *See Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 741 (7th Cir. 1986); *Donovan v. Dillingham*, 688 F.2d at 1375; *Davis v.*

Time Ins. Co., 698 F.Supp. 1317, 1321 (S.D. Miss. 1988); *Taggert* [sic] *Corp. v. Efros*, 475 F.Supp. 124, 127 (S.D. Tex. 1979), *aff'd sub nom., Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981).[3]

Finally, BCBSM asserts that the decision below will have far reaching impact because it eliminates employee benefit plans established by associations of employers from the coverage of ERISA. Again, the Florida appellate court made no such ruling. To the contrary, it correctly held that a plan which was not established or maintained by an association of employers was beyond ERISA's coverage. ERISA's requirement that a plan be established or maintained by an employer or employee organization to provide benefits to employees applies to all plans – including those involving an association of employers. BCBSM seems to criticize the Florida appellate court's reliance upon *Donovan* and *Taggart* because those cases involved multiple employer trusts as opposed to associations of employers, but the "established or maintained"

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[3] BCBSM correctly points out that the Fifth Circuit's holding in *Taggart* that an employer who subscribes to a multiple employer trust cannot thereby create an employee benefit plan has not been followed. This aspect of *Taggart*, however, had nothing to do with the Florida appellate court's decision. The two *Taggart* holdings which are pertinent to the decision below – that a plan established and maintained by entrepreneurial interests rather than ERISA employers is not an ERISA plan, and that the bare purchase of insurance by a businessman for his family does not create an employee benefit plan – have been approved and followed. *See Donovan v. Dillingham*, 688 F.2d at 1375.

principle those cases stand for applies equally to associations of employers.[4] Not only does ERISA make this clear, but the federal courts have done so by declining to find employee benefit plans when the association of employers or the employee organization involved did not establish or maintain the plan. *See Plotkin v. Association of Eye Care Centers, Inc.*, 710 F.Supp. 156 (E.D.N.C. 1989) (no plan established or maintained by group claiming, *inter alia*, to be an association of employers); *Baucom v. Pilot Life Ins. Co.*, 674 F.Supp. 1175 (M.D.N.C. 1987) (employee organization, if it existed, did not establish or maintain the plan); *Insurance & Prepaid Benefits Trusts v. Marshall*, 90 F.R.D. 703 (C.D. Cal. 1981) (association of employers did not establish or maintain the plan).

In sum, rather than making important new pronouncements of federal law with far reaching impact, the decision below simply applied settled principles of federal law in a recognized fashion.

2. The Florida Appellate Court Correctly Determined That No Employee Benefit Plan Exists Without Creating Conflict Among Decisions

Apart from the prolific use of hyperbole, BCBSM's claim that review is appropriate because the Florida appellate court's decision is "inexplicable" is based upon three major premises: (1) that the decision below conflicts

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[4] *Xaros v. U.S. Fidelity and Guar. Co.*, 820 F.2d 1176 (11th Cir. 1987), also cited by the Florida appellate court, confirmed in another context that only employers who establish or maintain a plan are ERISA employers.

with the decisions of the Ninth Circuit in *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, ___ U.S. ___, 109 S.Ct. 3216 (1989), and of a California appellate court in *Lambert v. Pacific Mutual Life Ins. Co.*, 211 Cal. App. 3d 456, 259 Cal. Rptr. 398 (Cal. App. 1 Dist. 1989), on "virtually identical" facts; (2) that both AGRA and Mr. Weiner's service station established employee benefit plans which meet the five-part test for a plan suggested by ERISA and the federal decisions; and (3) that the Department of Labor Regulation set forth in 29 C.F.R. §2510.3-1(j) (1989) requires a finding that both AGRA and Mr. Weiner's service station established ERISA plans.

As will be demonstrated below, each premise is flawed. The five-part test for establishing an employee benefit plan provides that one exists if:

> (1) a 'plan, fund, or program' (2) [is] established or maintained (3) *by an* employer or an employee organization or both, (4) *for the purpose of* providing [benefits] (5) to participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d at 1371 (emphasis added). BCBSM's analysis fails, however, on the critical connecting phases which are emphasized above. BCBSM asserts that a plan was established or maintained based upon the terms of the insurance contracts entered into between BCBSM and AFSI, and that AGRA is an association of employers which qualifies as an employer under ERISA. (Petition, pp. 12-13). Ignored, however, is the fact that the plan it perceives was not established or maintained *by*

either SSDA or AGRA. The insurance contracts BCBSM relies upon as setting forth the terms of the plan provide benefits to AFSI's employees, not SSDA or AGRA members and their employees. (PX. 29, 30, 31). SSDA never knew anything about these agreements, and was not a party to them. (R. 2004-2007, 2020-2021, 2038-2039). Likewise, AGRA never had any agreements with BCBSM (PX. 27; R. 2039-2040), and the group policies were administered by AFSI, not AGRA. (R. 3036, 7952). Further, AFSI admitted that it was not acting as AGRA's agent. (R. 1986).

On the association of employers level then, the plan was established and maintained by BCBSM and AFSI, not SSDA or AGRA. The fact that BCBSM fraudulently used SSDA's name changes nothing. When entrepreneurial businesses establish a plan to provide what otherwise would be ERISA benefits, no employee benefit plan is created. *Donovan v. Dillingham*, 688 F.2d at 1373; *Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d at 1210; *Hamberlin v. VIP Ins. Trust*, 434 F.Supp. 1196 (D. Ariz. 1977).

On Mr. Weiner's or the Weiner service station level, the insurance simply was not purchased for the purpose of providing benefits to his employees. The undisputed testimony at trial was that Mr. Weiner was purchasing insurance for his family, and only members of his family were insured. While one son worked for him, none of the other people working at the service station were

provided any benefits.[5] ERISA does not regulate the purchase of health insurance when there is no plan. *Donovan v. Dillingham*, 688 F.2d at 1375.

Ironically, the two cases BCBSM finds to be in conflict with the decision below actually underscore the reasons why there is no employee benefit plan in this case, and why the Florida appellate court ruled the way it did. In *Kanne*, an employee benefit plan was found to exist based on the fact that an association of employers purchased an insurance policy, that the employer group was designated as the plan administrator, and that the benefit booklet described the group insurance as an ERISA plan. This, of course, is what it looks like when an association of employers establishes or maintains a plan. In this case, however, the facts are just the opposite. Neither AGRA nor SSDA purchased an insurance policy or had any other agreement with BCBSM, neither of them was the plan administrator, and the benefit booklet never mentioned ERISA.

The same stark contract exists between the facts in *Lambert* and those here. In *Lambert* the employer entered into a subscription agreement for medical coverage for its employees; the agreement specifically provided that the

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[5] BCBSM's argument that the other people working for Mr. Weiner should not be considered employees for ERISA purposes because Mr. Weiner characterized them as "independent contractors" is wide of the mark. The employer's characterization is not the test. *See, e.g., Holt v. Winpisinger*, 811 F.2d 1532, 1538-39 (D.C. Cir. 1987); *Richardson v. Central States, Southeast and Southwest Areas Pension Fund*, 645 F.2d 660 (8th Cir. 1981).

plan was subject to ERISA; the benefit booklet contained information complying with ERISA's summary plan description requirements, including a statement of employees rights under ERISA; and the employer was designated as the plan administrator. Again, none of these critical facts are present in the instant case. No employer entered into a subscription agreement, much less one mentioning ERISA. The benefit booklet does not mention ERISA or otherwise comply with its summary plan description requirements.[6] And no employer was designated or acted as the plan administrator.

Finally, BCBSM's argument that the Department of Labor Regulation found at 29 C.F.R. §2510.3-1(j) compels a finding that an ERISA plan exists is legally incorrect. Relying on *Kanne*, BCBSM maintains that if all of the four criteria set forth in the regulation for excluding certain types of group insurance programs from ERISA's coverage are not met, the purchase of insurance in question automatically constitutes an ERISA plan. Both *Kanne* and BCBSM, however, overlook the Department of Labor's caution to the contrary:

> Some of the practices listed in this section as excluded from the definition of a 'welfare plan' or mentioned as examples of general categories of excluded practices are inserted in response to

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[6] BCBSM correctly notes that the failure to comply with ERISA's administrative and reporting requirements does not prevent ERISA coverage if an employee benefit plan has been established. Such failures are facts, however, which can be considered in determining whether a plan was established. *See, e.g., Jordan v. Reliable Life Ins. Co.*, 694 F.Supp. 822 (N.D. Ala. 1988).

> questions received by the Department of Labor and, in the Department's judgment, do not represent borderline cases under the definition in section 3(1) of the Act. *Therefore, this section should not be read as implicitly indicating the Department's views on the possible scope of section 3(1).*

29 C.F.R. §2510.3-1(a)(4) (1989) (emphasis added).

The court in the other case BCBSM relies upon did not miss this important preamble, and correctly noted that:

> it does not follow that an ERISA plan automatically exists when one or more of the four criteria are absent.

Lambert v. Pacific Mutual Life Ins., Co., 259 Cal. Rptr. at 403. Otherwise stated, 29 C.F.R. §2510.3-1(j) does not do away with the fundamental statutory requirements for an employee benefit plan – requirements not met here because there was no plan established or maintained by an employer for the purpose of providing benefits to employees.[7]

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[7] It must also be noted that, in making its argument under 29 C.F.R. §2510.3-1(j), BCBSM takes many liberties with facts. For example, BCBSM asserts that "AGRA received a per capita administrative fee to compensate it for endorsing and marketing the plan". (Petition, p. 15). This does not appear in the record. BCBSM also asserts that the Weiner service station paid the insurance premiums. While it is true that the check Mr. Weiner wrote said "Weiner Service Station" at the top (PX. 4), the account was also for personal use as demonstrated by the fact that Mr. Weiner paid for his non-employee son's insurance policy with a "Weiner Service Station" check as well. (PX. 11).

(Continued on following page)

The decision below, far from being inexplicable, correctly held that no employee benefit plan exists under the facts of this case.

3. It Was Proper for the Florida Appellate Court to Decide the Question of ERISA Preemption

BCBSM's repeated suggestion that review and reversal are warranted because the Florida appellate court decided the question of ERISA preemption for the first time on appeal is wide of the mark for several reasons.

First, the situation BCBSM complains of was entirely of its own making. While this Court did not address the question of whether ERISA preempts common law claims based upon the processing of a claim for benefits under an employee benefit plan until its 1987 decision in *Pilot Life*, the defense of ERISA preemption was not created by the *Pilot Life* decision, but by the 1974 Act. 29 U.S.C. §§1132(e)(1), 1144(a).

Where applicable, ERISA preemption was thus being raised as a defense to claims such as the Weiners' long before this case went to trial. *See, e.g., Phillips v. Amoco Oil Co.*, 799 F.2d 1464, 1469-70 (11th Cir. 1986), *cert. denied*, 481 U.S. 1016 (1987) (state fraud claim seeking damages

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Similarly, BCBSM quotes the insurance contracts as providing "that the '*Company* shall pay' the premiums". (Petition, p. 15). The contracts actually provide that the "Company shall pay *or cause to be paid. . . .*" (PX. 29, 30, 31). In addition, the "company" being referred to is AFSI, not AGRA or the Weiner service station.

for lost benefits preempted); *Powell v. Chesapeake and Potomac Telephone Co.*, 780 F.2d 419, 421-22 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (state law claims for intentional infliction of emotional distress, bad faith and breach of contract arising out of denial of disability benefits preempted); *Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1095 (9th Cir. 1985) (state law claims to recover wrongfully withheld retirement benefits preempted); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1214-16 (8th Cir.), *cert. denied*, 454 U.S. 968 (1981) (claims for tortious interferences and fraud arising out of denial of benefits preempted); *Drummond v. McDonald Corp.*, 167 Cal. App. 3d 428, 213 Cal. Rptr. 164 (Cal. App. 4 Dist. 1985) (state law claims for fraud and intentional infliction of emotional distress arising out of processing of claims for medical and disability benefits preempted). In short, if BCBSM had believed that the Weiners' claims related to an employee benefit plan, there was nothing to prevent it from raising the defense of ERISA preemption in the state trial court.

Second, in deciding whether an ERISA plan, and thus ERISA preemption existed, the Florida appellate court was doing exactly what BCBSM requested. Does BCBSM expect anyone to believe that it would be complaining about an incomplete record if it had prevailed on the issue.

Third, the Florida appellate court was also doing what this Court commanded that it do in *International Longshoremen's Ass'n v. Davis*, 476 U.S. 380 (1986). In the context of preemption under the National Labor Relations Act ("NLRA"), 29 U.S.C. §151 *et seq.*, which the

Court equated in power to ERISA preemption in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), the *Davis* Court reviewed the Alabama Supreme Court's conclusion that a NLRA preemption defense was waived because, like here, it was not raised until after trial. Holding that the Alabama Supreme Court should have resolved the issue, the Court held:

> A claim of [NLRA] preemption is a claim that the state court has no power to adjudicate the subject matter of the case, and when a claim of [NLRA] preemption is raised, it must be considered and resolved by the state court.
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> * * *
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> [The Alabama Supreme Court] erred in declining to address the claim on the merits.

International Longshoremen's Ass'n v. Davis, 476 U.S. at 393, 399. The Florida appellate court's action was thus in keeping with the mandate of this Court.

Finally, there is nothing untoward or unusual about an appellate court considering a preemption defense, based upon ERISA or otherwise, when the issue is raised for the first time on appeal. In this case, the Eleventh Circuit held that:

> [T]he Florida appellate court is an appropriate forum for determining whether the state trial court had jurisdiction. . . .

Blue Cross and Blue Shield of Maryland, Inc. v. Weiner, 868 F.2d at 1555. In *Kanne v. Connecticut General Life Ins. Co.*, the case most heavily relied upon by BCBSM, the Ninth Circuit did exactly the same thing. And this Court ultimately did it in *International Longshoremen's Ass'n v. Davis*. There is simply no rule of law precluding consideration

of an ERISA preemption defense for the first time on appeal.

CONCLUSION

For the above reasons, it is respectfully submitted that BCBSM's Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.,

Petitioner,

v.

ROBERT WEINER, SR., MARGARET WEINER, MARK WEINER,
AND ROBERT WEINER, SR. AS PERSONAL REPRESENTATIVE
OF THE ESTATE OF STEVEN WEINER,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
FOURTH DISTRICT COURT OF APPEALS OF FLORIDA

REPLY IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE FOURTH DISTRICT COURT OF APPEALS OF FLORIDA

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ARGUMENT

Petitioner Blue Cross and Blue Shield of Maryland, Inc. ("BCBSM") submits this Reply in Support of its Petition for a Writ of Certiorari.

The Florida State Intermediate Appellate Court determined that, where an employer purchased insurance through a trade association group insurance plan, with eligibility limited to employees of the member businesses, no ERISA plan existed, merely because the employer was a

small family business and the covered employees were also members of the employer's family. The Florida State Court's decision would deny ERISA's protections to many thousands of employees in small, family businesses. Moreover, by exposing employers and their insurers to the ruinous punitive damage awards which can result from state court tort litigation, it will discourage the provision of insurance to employees which ERISA was designed to promote.

The decision thwarts the mandate of Congress. It ignores this Court's decisions recognizing the unique federal interest in ERISA, exemplified by exclusive federal jurisdiction over the ERISA claims at issue here, and ERISA's complete preemption of state statutory and common law policies.

Respondents state that neither Plan was an ERISA Plan. The argument that the Weiners' "Station Plan" is not an ERISA plan is flawed by the inherent contradiction in Respondents' "Brief in Opposition" to the Petition. Thus, Respondents argue that Robert Weiner, Sr. desired only to obtain coverage for his family, and that he never provided insurance for employees who were not family members. This, they state, is dispositive in determining that the Station Plan was not an ERISA plan (Brief in Opposition at 8-9). They ignore the fact that there *were no other employees* (other than Mr. Weiner and a son). They dismiss Mr. Weiner's testimony characterizing the other employees at the station as simply "independent contractors" as "not the test." (Brief in Opposition at 17n5.) Thus, Mr. Weiner's views are either critical, or irrevelant, in accordance with Respondents' convenience.

Respondents cite several cases as support for the fiction that no ERISA plan was established because Mr. Weiner simply desired to purchase insurance for his family (Brief in Opposition at 12-13). None of these cases support that proposition.

The initial holding in *Taggart Corp. v. Life Health Benefits Administration,* 617 F.2d 1208 (5th Cir. 1980), *cert. denied,* 450 U.S. 1030 (1981), that a multiple employer trust ("MET") is not an ERISA plan, is inapposite, because the employer association plan involved in the present case is *not* a MET. The second *Taggart* ruling — that the employer, by subscribing to a MET, had not established an individual employee welfare plan covered under ERISA — has been rejected in subsequent decisions, and was reversed by Congress when it amended ERISA in 1982 (*see* BCBSM's Petition at 16-18). Each of the other three cases cited by Respondents, *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.,* 805 F.2d 732 (7th Cir. 1986); *Donovan v. Dillingham,* 688 F.2d 1367 (11th Cir. 1982); and *Davis v. Time Insurance Co.,* 698 F.Supp. 1317 (SD.Miss. 1988) found that the plans in question were covered by ERISA because the employer (like Respondent Robert Weiner, Sr.) purchased insurance to cover employees and their dependents.

Since Mr. Weiner's Station Plan was an ERISA plan, this litigation was governed by ERISA.

In support of their view that the "Association Plan" was not an ERISA plan, Respondents contend that the broker and administrator for the plan, Association Financial Services, Inc. ("AFSI") was providing benefits only for its *own* employees, and benefits were not provided for members of the Allied Gasoline Retailers Association of Florida ("AGRA"), the Florida affiliate of the Service Station Dealers of America ("SSDA"). (Brief in Opposition at 7-8.) In fact, it is undisputed that AGRA endorsed the Group Plan and its representatives enrolled participating employers (AGRA members) and their employees. Nevertheless, Respondents insist that AFSI, not AGRA, "established or maintained" the Plan.

The foundation for this argument is Respondents' contention that "AFSI's President confirmed in trial testimony that AFSI was not in any way acting on behalf of AGRA."

(Brief in Opposition at 8; *See id.* at 16.) The carefully excised testimony cited fails to disclose that the question to which AFSI's President responded related to AFSI's preliminary efforts to persuade AGRA to endorse the Plan, a prerequisite for AGRA members to obtain coverage under the Plan. Obviously, AFSI could not have been acting on *behalf* of AGRA at the same time it was seeking AGRA's endorsement. After it received the endorsement, it became broker of record for AGRA. The testimony which surrounds the quotation cited by Respondents (*see* Brief in Opposition at 8) places the quotation in its proper context:

> Q. *When you were presenting this program to Florida [AGRA]*, was Florida consider[ing] other programs at the same time?
>
> A. Yes.
>
> . . . .
>
> Q. Well it probably follows from the question I asked about the fact that *you were in competitions [sic] with others for this business*, you were not, as far as this business was concerned, acting in any capacity as agent for this state organization [AGRA], the Florida state organization; were you?
>
> A. No.

(R. 1985-87) (emphasis added).

Relying on this legerdemain, Respondents argue next that AFSI was only providing benefits for its own employees under the Association Plan (Brief in Opposition at 7-8). This argument fails, since the foundation upon which it rests is false. Once AGRA endorsed the Plan, AFSI acted as broker and administrator of the Plan. The Plan was not formed for the purpose of or with the effect of covering AFSI employees. Indeed, Mr. Weiner himself was covered by and sued for cov-

erage under the Plan (as well as under the Station Plan); he, of course, was not an AFSI employee. While the Plan "benefits book" did not mention AGRA by name (Respondents' Brief at 7-8), this argument too is misleading: it did refer to the individual local associations of the Service Station Dealers Association of America, of which AGRA was one. (*See* exhibits cited in Brief in Opposition at 8.)

Finally, Respondents cite three cases as purported examples of employer association-sponsored plans which were found to be outside of ERISA's coverage. (Brief in Opposition at 14.) However, *Plotkin v. Association of Eye Care Centers, Inc.*, 710 F.Supp. 156 (E.D.N.C. 1989) and *Insurance & Prepaid Benefits Trust v. Marshall*, 90 F.R.D. 703 (C.D. Cal. 1981), hold simply that a MET is not an ERISA welfare benefit plan. In *Baucom v. Pilot Life Insurance Co.*, 674 F.Supp. 1175 (M.D.N.C. 1987), the Court held that a retirement plan established by a state professional golf association was not an ERISA plan because the association was not an "employee organization." There, unlike in the present case, the defendant did not even argue that the plan was subject to ERISA on the ground that it was established or maintained by an association of employers.

CONCLUSION

This Court recognized in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) that:

> "[T]he federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

A writ of *certiorari* should issue in order to prevent precisely that result.

Respectfully submitted,

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